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ABSTRACT

This reader contains stories to accompany the Reading Manual. It is part of the package of materials developed for use in an English for Special Purposes project, which offers classes in reading, grammar, and emergency care attendant training for limited English proficient students. These stories may be selected as supplementary reading for exercise seven in each of lessons 2 to 8. Section 1 lists various activities that use the newspaper in improving reading skills. Section 2 contains 37 newspaper articles. Section 3 offers suggestions for developing comprehension using journal articles. The suggestions center around two major areas: the skill of asking questions appropriate to the skill to be taught and practice of the skills of comprehension. Nineteen journal articles appear in Section 4. Section 5 is a checklist where the student can record his/her completion of the recommended two newspaper selections and one journal selection for directed weekly study. (YLB)

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English for Special Purposes
Emergency Care Attendant

Reader

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EMERGENCY
CARE
READER

A SUPPLEMENT TO THE
EMERGENCY CARE ATTENDANT READING MANUAL

THIS PROJECT WAS FUNDED BY THE TEXAS HIGHER EDUCATION COORDINATING BOARD THROUGH A GRANT UTILIZING FUNDS FROM THE CARL D. PERKINS VOCATIONAL EDUCATION ACT

PROJECT NUMBER 88104009

PROJECT YEAR 1987

CARL D. PERKINS VOCATIONAL EDUCATION ACT GRANT

ENGLISH FOR SPECIAL PURPOSES/EMERGENCY CARE ATTENDANT TRAINING MODEL FOR EARLY ENTRY INTO ALLIED HEALTH OCCUPATIONAL PROGRAMS

DR. JERRY B. GATHINGS, PROJECT DIRECTOR

ECA READER

Dear Student,

The stories accompany the Emergency Care Attendant Reading Manual and may be selected as Supplementary Readings for Exercise Seven in Lesson 2-8. Newspaper Articles and Journal Selections are included and may be read in any sequence.

Material may be used as enrichment and as the "spring board" for excellent topics designed to stimulate interesting discussions.

The pages entitled Comprehension Activities are suggested models for an individualized reading program to be integrated into the Supplementary Reading and Journal Component in the Lesson 7 Exercises. Two newspaper articles and one journal selection are recommended for directed weekly study in the individualized reading program in addition to four student selected articles. Excellent readings can be selected from the series entitled Timed Readings by Jamestown Publishers which is available in the Reading Labs at the Valle Verde, Rio Grande, and Transmountain Campuses. The Computer Assisted Instructional Programs provide additional readings that can be included to provide a variety of individualized reading materials.

I hope you enjoy reading the informative articles.

Sincerely,

Your Instructor

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USING THE NEWSPAPER IN IMPROVING READING SKILLS IN THE CLASSROOM

Reprinted from The Content Reader - A Handbook for The Teacher.

OBJECTIVE

1. **ENCOURAGING RECEPTIVITY**
(We often classify as "reading" motivation.)

A. Pass out newspaper copies to students and ask for comments as to what interests them most in that edition.

B. Discuss a specific news item.

Use of a visual aid to begin a discussion by cutting out an editorial cartoon and inserting it with transparency film into a thermal copy machine to use on an overhead projector.

Locate material through the index on the front page.

Relate experiences generated by skimming the paper for stories to be read.

Relate sections to be read to those already studied.

Speculate as to what might happen in some of the comics before turning to them.

Learn the difficult vocabulary of a news story or item which the whole class is to read.

Set reading goals for the lesson with the teacher.

Develop an appreciation of percentage and fractions in math by comparing prices of advertisements, stock market quotations, sports print-outs, etc.

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2. **GUIDING SILENT READING**
(This is the first type of reading a student should do when encountering new material. It is guided by the instructor through questions to be answered, opinions to be expressed, the sequences of events to be identified including: reading for specific information, finding facts, making inferences, searching for the central thought, developing new interests, associating past experiences with the material being read, investigating the writer's biases, following a sequence of ideas, clarifying concepts.)

As students read silently, the instructor gives individual help in word recognition skills or discerning important facts.

The instructor can get to know students better by using the newspaper to prompt an enlightening conversation with an individual which would never come out in a regular class discussion.

C. Detection of visual problems as well as numerous other silent reading difficulties of students through observation and individual contact.

Corrective measures may be taken promptly and individual exercises prescribed to assist those having difficulties.

D. Exercises to improve rate of reading and developing reading rate flexibility may be given

3. **GUIDING SKILL DEVELOPMENT**
(Word recognition, comprehension, rate, and flexibility as well as other reading skills can be developed.)

Develop both instructor and student awareness of strengths and weaknesses in reading skills by keeping reading skills checklists. The checklists record the age and grade level of the students and the particular purposes for reading.

4. **GUIDING REREADING (Silent & Oral)**
(The newspaper lends itself to rereading since the students often wish to share items of interest.)

A. Retelling accurately what has been read.

B. Preparing a comic strip for dramatization.

C. Gathering of data for drawing an editorial cartoon.

D. Answering specific questions.

E. Rereading for sheer enjoyment.

****

ORAL REREADING

A. Documenting answers to questions.

B. Reading aloud humorous incidents found during silent reading.

C. Stimulating the interests of other class members.

D. Practicing reading with expression.

E. Conducting "news broadcasts" or "telecasts" (simulated).

5. **CONTINUATION ACTIVITIES**
(This is to extend and broaden those items found in the newspapers.)

A. Browsing through other newspapers.

B. Concentrating on certain areas of reading in the paper such as science, editorials, and finance.

C. Writing short stories based on news items.

D. Interviewing a local reporter or person in the news for more background information.

E. Writing a background report on a well-known person or country in the news.

F. Visiting activities (sporting events, trials, special events, places, etc., and comparing personal accounts with the news items.)

G. Doing a crossword puzzle.

H. Clipping local, state, national and international news items from the paper and arranging them appropriately on a bulletin board (perhaps even through the use of pins and strings identifying their locations on a map.)

* * *

I. Maintaining emergency care stations and/or developing data.

6. **DEVELOPING CRITICAL READERS**
(A number of factors influence comprehension and critical readings, the most important being general intelligence. Others include the limits of a meaningful vocabulary, the ability to organize material after reading, the rate of reading, the interest value to reader, background of the reader's experience for the particular material read and readability of the material.)

A. Any activity designed to develop the factors mentioned would be suitable.

B. Enlarging the scope of news items through class discussions.

C. Conducting debates on issues cited in the editorial pages.

D. Class discussions on reasons why certain events described transpired.

E. Obtaining "first-hand knowledge" of events described by inviting news makers to the classroom for presentation.

F. Detailed examinations of reporter's and columnist's background to fix their credibility.

7. **COMPREHENSION**
(Two fundamentals underlie any lesson geared toward comprehension improvement: sufficient background experience and an established purpose for reading.)

A. In developing the skill of comprehending the MAIN IDEA, write headlines for news stories that have been "decapitated". Testing situations can be set up by pasting the headline from a newspaper article on one side of a card with the article on the reverse side. As the numbered cards are passed around the room, the students read the article, write down their own headline on a numbered paper and pass the card to the next person. When all have finished writing their own headlines compare the newspaper headlines with those written by students.

* * *

B. Practice in using the five W's (who, what, where, when, and why) by finding the answers to those in the articles selected.

C. Composition writing by using the five W's as an outline and having students recreate and/or condense articles.

D. Listening skills can be developed also by having students use the five W's as outlined to record information obtained from listening to an article read by the teacher or another class member.

E. Class discussions on why certain items were placed on specific pages of the paper.

F. Class discussions on improving the organization of the newspaper, placement of articles, items, advertisements, photographs, etc. Justification for changes should be thoroughly discussed.

8. **DETAILS**
(Students might search a newspaper article for answers to teacher-developed questions.)

A. Looking at a picture to locate details for about 30 seconds, cover it and list as many details as can be remembered.

B. Duplicating an outline in which only the main ideas appear but where the details are to be found in the newspaper story can be a total class activity.

C. "Proving a Point" questions can make students more aware of how important details are in fully understanding their reading. The answers to inferential questions often rely on details sometimes passed-over in cursory reading. In drawing an inference, the reader must identify those details which may be missing in the article.

9. **SEQUENCE**

A. Ask students to tell in sequential order, numbering if necessary, what happened after reading an article or comic strip.

B. With a comic strip, cut out the individual frames after pasting them on a cardboard backing. Shuffle the frames and have the students place them in correct order on a chalkboard ledge or on a desk.

C. Causes and effects using organizational guides such as "What happened?" Under this column a news item would be placed, "A plan to group and racially balance five schools suffered a serious setback last night when both black and white parents attacked it." In a column opposite this, labeled "Effects", the students would fill in their answers on the basis of what else is included in the article and on their own thinking.

10. **FOLLOWING DIRECTIONS**
(Many sections in the newspaper require the reader to follow directions. These sections can be discussed and used in the classroom.)

A. Prepare classified advertisements.

B. Write letters to the editor and check that they correspond to the instructions listed in the paper. Also check the letters published for compliance with instructions.

C. Do crossword puzzles, cryptograms and other amusement activities.

	D. Prepare dishes according to printed recipes.
	E. Play bridge or chess games described in the paper.
11. **PREDICTING OUTCOMES** (This requires a deeper understanding by the students of events described and immediate reinforcement is provided to the students by sequential readings of editions.)	A. Students can predict what will happen to certain characters and prepare two or three possible conclusions based on past readings of comic strips.
	B. Determining outcomes of courtroom conversations, pending congressional bills, winners of the Academy Awards, approaching elections, World Series, football games, etc.
	C. Deciding the stances taken by foreign countries who face deadlines for action and all of the problems awaiting conclusions which can be predicted.
12 **CRITICAL READING** (Students should be encouraged to back up their reading of the newspaper by knowledge gained from a variety of source material from available, i.e., encyclopedia, almanacs, history books, etc.)	A. In order to identify the parts of the newspaper most likely to contain facts about important events as opposed to personal articles, divide a bulletin board into two sections, one labeled "PERSONAL OPINION" and the other "FACTUAL." Under the first heading the following articles might be grouped: advertisements, editorials, letters to the editor, columns by well-known newsmen, book reviews. In the "FACTUAL" column would be articles like: news stories, court announcements and death notices.

B. A bulletin board display could be set up on a controversial subject. One side of the board would have articles taking one point of view while the other side would represent the opposite stance. The reading of these articles would precede a debate or classroom discussion.

C. In-depth reading of pictures and editorial cartoons makes for interesting discussions and debate in determining why a cartoonist expressed himself in this way.

D. Book, play, TV and film reviews are also useful for developing critical reading. Students can accumulate the review sections of newspapers over a period of a few weeks and then compare how the various reviewers agree or disagree.

E. Editorials, especially need to be read critically because they influence and mold public opinion. With various colors of crayon or felt pens, students can underline the program, assumptions, opinions, facts, and conclusions of the editorial.

13. **PROPAGANDA**

(Propaganda is defined as any organized effort to spread a particular doctrine or information. The term has now taken on unethical overtones making anything designated by this label suspect and open to unusual scrutiny.)

Students need to be alerted to and to look for the methods advertisers and others use in contending for money for the written word. The following list of slogans and emotional terms was gathered within a few moments from a single newspaper. Students need to analyze such terms to determine their degree of truth: "A titilating smash", "problem perspiration solved", "save up to 50 percent", "Super Buys!", "Tremendous Values!", "Prestige Location", "First time ever at this low, low price", "Don't ask how much it costs; ask how little it costs to operate", "Think young", "Buy direct and save $$$", "Volume Prices!", "We need your care!".

14. **DEVELOPING VOCABULARY AND WORD IDENTIFICATION SKILLS**

(Two standards must be kept in mind when selecting any vocabulary activity. First, the activity must be of high interest and low learning difficulty. Secondly, the activity must not present too many new words at one time.)

A. Some sports' writers make comparative references to teams or individuals such as David and Goliath or Samson. Allusions are often made to Socrates and his hemlock. Collecting these allusions can broaden the student's reading interest and develop his vocabulary.

B. Vocabulary booklets can be developed from various parts of the newspaper, sports, financial, and editorial, for example. The words can then be alphabetized and used in written assignments.

C. Who, what, when, where, and why words and phrases can be collected for a vocabulary study.

D. Lists of words of feeling and action can be helpful in developing vocabulary.

E. Vocabulary cards can be developed with the word from the newspaper on one side and the dictionary definition and a newspaper sentence using the word on the other side. A variation of tic-tac-toe can be played using the cards as questions. Whenever a correct response is given, the responder puts his "X" or "O" in the space.

F. For an interesting break in skill sessions, have students dramatize or play charades with words they select from a designated page in the newspaper. Dramatization is an excellent way to develop a deeper and more lasting understanding of words.

G. Crossword puzzles can be made by students using the words from a newspaper. These can be duplicated and passed around for the class to complete. Definitions should be checked with the dictionary.

H. Selected words found in the newspaper can be written on the chalkboard. A checkmark or the student's initials is placed after each word each time the word is used orally in class.

I. Students may make up riddles which describe words from the newspaper lesson. Other class members try to guess the word. The winner gets an opportunity to give a riddle or select someone else to do so.

15. **READING RATE ACTIVITIES**

(Since there is no rate appropriate to all reading situations, a modification of the four described by Albert Harris are particularly adaptable to newspaper reading. These are skimming and scanning which are the fastest. Skimming is used to pick up the central theme while scanning involves a rapid search for locating a specific bit of detail. Rapid reading is the rate at which material is read for pleasure or relaxation. A normal rate is used when a person wishes

A. Skimming practice is provided by having students quickly identify the themes of editorials, the five W's in new's articles and the main ideas expressed in syndicated columns.

B. The newspaper is adaptable to the SQ3R method of study. The Survey (s) portion of the method begins with a look at the title, subhead and dateline. Then the student scans the article for uncommon words and pictures or graphs which

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to find answers to specific questions, to solve a problem, or to read material of average difficulty. To master the main ideas and pertinent details of a selection the student must develop a careful rate of reading. At this slower rate he is able to get details in sequence, evaluate materials, outline and summarize, and read material with unusual vocabulary and style.

accompany the article. The student then formulates a question (Q) which may be generated by the headline, subhead or first line of the article. He then reades (First R) to answer the question, recites (Second R) his answer to himself by looking away from the material (to assist memory), forms another question, reads for that answer, and recites again. If the student has difficulty generating his own questions, he may use the five "W's" referred to earlier. At the conclusion of the article, the student reviews (Third R) what he has read and summarizes in his mind or on paper.

C. One practice for increasing rate is to have students read any page they wish for one or two minutes. Then have them fold their papers and tell their classmates or list on a sheet of paper as many facts as they can remember.

D. Other rapid reading exercises which may be used are: to skim and identify which articles deal with local, state, national, or international news; scan datelines to find stories which originate in a country being studied; scan for names of outstanding politicians, sports figures, or famous personalities; skim for the best/worst news of the day; scan for advertisements of the lowest priced car of a particular make and year; scan for the best value of a specific brand of canned fruit or medicine.

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16. ADDITIONAL ACTIVITIES

A. Looking at and discussing classified ads to identify occupations.

B. Finding words already known to class members.

17. SUMMARY

The foregoing is but a minute listing of the various activities possible in using the newspaper to teach basic skills in the classroom. For each one listed, there exists thousands of others the nature of which is limited only by the ingenuity of the instructor. Oftentimes the students themselves may devise additional activities which may prove successful. Each instructor, using the newspaper, is encouraged to develop and store, in some accessible repository, his/her own list of activities; adding to this list as newer ones are tried successfully.

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EL PASO TIMES
April 1, 1988

by Amber Smith

PARAMEDICS'S MOM RIDS ALONG

Nurse experiences firsthand look at job

The nurse who rode in the back of an ambulance for six hours Wednesday night was more than just a guest.

She is a paramedic Randy Crum's mother, who is visiting El Paso from Shaumburg, Ill., outside of Chicago.

Because Carlyne Crum, 57, works as nurse, her son thought she'd be interested especially in seeing firsthand what he does for a living.

With permission from his superiors, Crum, 30, arranged for his mother to tag along with him and partner Mary Moran.

Emergency Medical Service's policy allows medical students and people training to become paramedics to ride along to see what it's really like. The policy also allows immediate family members to ride along.

Darlyne Crum was simply an observer, so she was not permitted to render care to any of the ambulance patients. But she and the crew were able to discuss the needs of the patients after they had been transported.

Randy Crum said he and his mother also discussed the differences in their lines of work.

"Obviously she's not, in her terms, 'zipping around the streets.' She's involved in more long-term care. We see them pre-hospital for about the first hour," she said.

Darlyne Crum said: "It's kind of surprising to me that my son turned into a paramedic. I've got three daughters, and none of them ever were interested in anything medical."

She said her son must have become interested in saving people's lives soon after he began swimming: "He took the CPR classes, and it kind of escalated from there."

Randy Crum has worked with the city ambulance service for seven years.

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EL PASO TIMES
April 1, 1988

THE ONE THAT ALMOST GOT AWAY
Photographer's quick action at tot's rescue wins him Pulitzer Prize

As rescuers pulled toddler Jessica McClure from a well after 58 hours, hundreds of camera shutters recorded the event, but it was Scott Shaw's shot that got the Pulitzer Prize for spot news Thursday.

Shaw, 24, a photographer for the Odessa American, said he had not been expecting the prize for coverage of the Midland, Texas rescue.

"I had heard that I was in the final three about two weeks ago, but it was hard to believe that I could even have a chance to win such a big award," Shaw told The Associated Press Thursday. "I am pretty proud. I am just pretty surprised."

But he said colleagues had been predicting the award.

"She (Jessica) whizzed by me with the rescue worker in a split second and I got a shot off," Shaw said of his photo. "I was going to change lenses to get a shot of the rescue."

"But I held the camera up before I got a chance to change lenses. I raised the cameria and saw a blur through the viewfinder of the rescue worker and Jessica. I focused and got the one shot off."

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EL PASO TIMES

MAN WHO LOST HAND IN EXPLOSION DIES

A 37-year old man died Monday, two days after an explosion blew off his hand and burned most of his body.

Armando Esparza died at 4:00 p.m. Monday at Thomason Hospital.

Nursing supervisor Donald Harrison did not give details regarding the cause of death.

The explosion was Saturday afternoon at the South El Paso apartment of Esparza's sister. Esparza had been pouring gasoline from a 5-gallon canister into a smaller container.

The apartment's forced-air heater kicked on and ignited the gasoline fumes, fire officials said.

Esparza lost his hand and was burned over more than 60 percent of his body.

A neighbor heard Esparza scream and drove him to Thomason Hospital.

Esparza's sister, Estella Ortiz, had to jump 15 feet to the ground to escape the burning apartment, but she was not seriously injured.

The fire gutted her apartment at 1901 Corona. A neighboring unit sustained minor smoke damage.

District Fire Chief David Guillen said the fire apparently started on the ground floor, near the kitchen in the rear of the apartment.

"We're not sure if (Esparza) was working there, but he had a bunch of tools scattered about," Guillen said Saturday, shortly after the accident.

Esparza had been listed in critical condition since he was admitted to the hospital.

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EL PASO TIMES

PARAMEDIC HELPS MOTHER SAVE GIRL, 4, FROM DEATH IN CREEK

Bonenumbing cold didn't make a paramedic abandon his search for a child trapped in a car that hit an icy patch and slid into a creek near Lake Ray Hubbard.

"I wasn't coming out until I found that kiddo," said Richard Strange, a firefighter for nine years but a paramedic for only four months, who was credited with rescuing the 4-year-old girl.

Strange, 29, said he knew Morgan Murphy was trapped somewhere inside the submerged vehicle resting upside down in the creek. He was about shoulder-deep in the icy water when he reached the open driver's door.

The girl was one of three children in the car that slid off icy State Highway 66 at about 7:00 a.m. Thursday.

"I could see us be nothing but headlines tomorrow." Karen Murphy, the girl's mother, said from her hospital bed.

A biting northerly wind had pushed the wind-chll factor to minus 17 degrees when the car went into the water.

Morgan and her brother Stuart, 2, were released from Lake Pointe Medical Center Friday. Both had been in the critical care unit for treatment of hypothermia and precautionary observation, hospital spokeswoman Cindy Reisenbichler said.

Last month, Betty Stenline and her two young daughters drowned after their car skidded on an ice-covered causeway and plunged into Lake Ray Hubbard a few miles from the Murphy's accident.

Karen Murphy, 27, pulled two of her children from the murky waters before the dramatic rescue effort.

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EL PASO TIMES

JOCKEY INJURED AT SUNLAND

The danger of horse racing was apparent at Sunland Park on Friday as one jockey was hospitalized and another escaped injury when his horse collapsed.

Jockey Joe Holmes was treated and released from Providence Hospital after his mount in the fourth race, Bradley's Khalie, appeared to stumble.

A nursing supervisor at Providence, Patsy Wofford, refused to disclose the nature of Holme's injuries, though the jockey appeared to be favoring his right shoulder. It was not known if Holmes would be available to ride today.

Jockey Darrell Blevins was more fortunate. He was not hurt when his horse, Rebeille, collapsed and died just after rounding the turn in the 1,000-yard seventh race.

Rebeille, a 9-year-old quarterhorse owned by Donna Martin of El Paso and trained by Ike Danley, appeared to weave while rounding the turn before collapsing. Rebeille, who had finished second and first in his last two starts before Friday's race, won $38,682 in his career.

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EL PASO TIMES

SUIT FILED OVER '87 INDY DEATH

A wrongful death suit seeking $9 million dollars has been filed by the widow of a Wisconsin man killed by a flying tire at the 1987 Indianapolis 500.

The suit was filed Thursday against the Indianapolis Motor Speedway, U.S. Auto Club and other defendants.

Lyle G. Kurtenbach, 41, of Rothschild, Wis., was killed when a tire from a car driven by Tony Bettenhausen flew high into the stands and hit him on the head during the May 24, 1987, race. Kurtenbach was watching the race with his wife, step-daughter and eight other relatives.

Mrs. Kurtenbach claims the car and tire were defective and that spectators were not adequately informed of the potential dangers of watching the race. She also claimed USAC did not inspect the cars well enough and did not have enough safety barriers around the track.

Bettenhausen also was named in the suit, but he said he did not know anything about it. Bettenhausen said he realized there was a problem with his car just before the accident happened, but was heading into the pits to find out what was wrong when the tire flew off.

Officials at the Speedway could not be reached for comment.

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EL PASO TIMES
March 19, 1987
by Ramon Bracamontes

DOUBLE CAVE-IN KILLS CONSTRUCTION WORKER

Safety agent to investigate site

An El Paso man was killed Wednesday after a 20-foot deep hole in which he was working caved in twice, burying him under several feet of dirt for almost four hours.

John Charles McLaughlin, 37, of 8450 Gateway East, was trying to find a sewer line in the middle of Pebble Hills, about 100 yards east of Lee Trevino on the East Side, when the first cave-in occurred at about 11:30 a.m.

Two co-workers, Crispin Melendez and Robert Bordada, jumped in and had managed to remove the dirt from around McLaughlin's head and face when the second cave-in occurred.

"He was all right after the first cave-in," Melendez said as he clutched a picture of Pope John Paul II that was on his key chain.

"We had the top half of him uncovered. Then the second one came. I had him in my arms, but I couldn't pull him." Several feet of dirt covered McLaughlin again. Melendez was not covered, but Bordada was covered to his waist. It took 20 minutes to free him.

Bordada was taken to Vista Hills Medical Center, where he was reported in stable condition late Wednesday.

It took about 20 El Paso firefighters, paramedics, police officers and construction workers until about 3:15 p.m. to recover McLaughlin's body.

"For every bucket of the dirt they pulled out, two more fell," District Fire Chief C.L. Gagnon said.

"There were cracks in the walls that were ready to cave in," Gagnon said. "We had to be careful. We didn't want to lose anyone else." Gagnon said firefighters had to put plywood sheets on the sides of the hole to prevent a third cave-in.

"That's the hazard of the job these men were doing." Gagnon said. "Every time you dig a hole the sides can cave-in."

During the rescue effort McLaughlin's wife, Kathleen, stood off to the side, leaning against a fire truck, speaking only to police Chaplain Bill Welsh.

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Not until her husband's body was pulled out did she lose hope.

Aided by Welsh and a man identified only as her husband's grandfather, she walked over to an ambulance to look at her husband's body.

"No, no," was all she said.

James E. Regan, who owns the excavating company for which McLaughlin was an experienced worker, said that the hole was wide enough to keep the wall from caving in.

"I don't know what caused the cave in," Regan said. "Maybe the vibrations from the cars passing by. People see us working, but they never slow down. We should have closed the road completely."

Larry Palacios, an inspector with the U.S. Occupational Safety and Health Administration in Lubbock, was expected to arrive in El Paso early today to begin an onsite investigation into the accident, David Garcia, safety supervisor at the agency, said.

Garcia said Palacios will determine whether the walls of the hole were reinforced.

"You have to take precautions with sandy soil like you have in El Paso," Garcia said, noting that construction holes or ditches dug deeper than 5 feet in earth other than solid rock should have some form of shoring or protection for workers to prevent cave-ins.

Garcia said records showed that Regan's company was cited in 1984 for not having a fire extinguisher on a truck.

Other than that, "We haven't had any problems with him at all," Garcia said.

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EL PASO TIMES

I-10 PLANE CRASH IN RUSH HOUR KILLS 3

Chuck Espersen saw the flash, then the flames, and suddenly he was running toward the airplane that crashed nose-first Friday into Gateway East.

As he got closer, Espersen saw the boy. And then the boy caught fire.

Espersen dragged him away from the burning wreckage. "I kept seeing his face, then I would see the face of my son, who isn't too much older, and I kept telling myself, 'God, I want to save this boy.'"

But Jesus Aaron Puentes, 11, had died the moment the plane hit the ground, police Lt. J.R. Grijalva said. He suffered massive head injuries.

The child's mother, Rosa Linda Puentes, 31, of the 3500 block of Louisville, and the pilot and owner of the plane, Don McCoy, 57, of the 2500 block of McKinley, were killed, burned beyond recognition.

McCoy was President of El Paso Sand Products Inc. Rosa Linda Puentes was his secretary.

The plan crashed into the 6200 block of Gateway East, east of Geronimo Drive. Espersen, 45, a refrigeration contractor, was waiting for a traffic light at Gateway West and Geronimo. When he saw the explosion, he got out of his car and ran to the wreckage.

There was Jesus Aaron.

"He was lying on the pavement. His hand was near the wheel of this burning airplane. There was a peaceful look on his face. And then fuel started dripping on his face and he just caught on fire."

"I got there and his face was burning, his arms were burning, then he was burning all over his body. I tried to reach him but the goddamn airplane exploded and knocked me back about 10 feet."

"So I got down and crawled up and grabbed him by the feet and pulled him away. I tried to put out the fire that was burning him. I rolled him over. Then I splashed some water that was in the gutter from the rain and snow. And then I rolled him over again, and splashed on some more water."

The twin-engine Aero Commander 680 took off from El Paso International Airport at about 8:50 a.m. Friday, bound for Palm Springs, Calif., said Frank Boone, air traffic manager for the Federal Aviation Administration tower at the airport.

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The plane took off during a snowstorm. Visibility was about three miles and the cloud ceiling was about 600 feet, but Boone said his opinion was that weather was not a factor in the crash.

"There was an indication of a possible problem with the landing gear and he was attempting to come back to the airport," Boone said.

The plane took off to the east, turned south, then headed west. It then turned south or southwest.

"And that's when he lost radar and radio contact." Boone said. He estimated the time of the crash as 8:54 a.m.

When the plane crossed over Interstate 10, a wind struck a citizen's band radio antenna on a passing truck, according to a police report.

The plane cleared I-10, struck an embankment above Gateway East and crashed nose-first onto the roadway, the police report states.

Some witnesses told police that the engines were not on, or that they were sputtering. One witness said he saw smoke trailing from the plane.

Holden Lewis, the El Paso correspondent for The Associated Press, was stuck in traffic on Gateway West when he looked to his left and saw the plane over Interstate 10.

"The wings were perpendicular to the highway," Lewis said. "It looked like the wings were no more than 50 feet above the traffic. It disappeared over the other side of the elevated highway. I kept thinking it would pull up."

Across the highway, Homero Velasco was pumping gasoline at his Exxon service station at Gateway East and Geronimo.

He said he heard a noise and saw the plane explode. The craft bounced and hit two unoccupied vehicles on a parking lot.

Velasco said the first thing he did was run inside and turn off the gasoline pumps.

People came running from nearby offices and were forced back by the heat. Many stood in the blowing snow and rain and watched in horror as police and firefighters arrived.

The firefighters sprayed foam on the wreckage.

"We could see the smoke from Geronimo and Montana," said Fire Lt. Raul Tarango of Station 13, 5413 Trowbridge. "When we got there, we couldn't see exactly what was involved because it was so thick, and then the cars were burning too."

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Then Tarango spotted the boy's body on the pavement. "At that point I said, 'Well, that's it; nobody else is alive.'"

A priest from a nearby church came to comfort witnesses.

Police closed off Gateway East between Geronimo Drive and Robert E. Lee Road. Sgt. Rudy Tabbutt said the street was reopened at about 5 p.m. after being blocked for 8 hours.

Investigators from the Federal Aviation Administration and the National Transportation Board came in from Albuquerque and Forth Worth. After inspecting the crash site, they had the debris moved to a hangar at the airport.

The investigators will resume their inspection of the debris early this morning.

A little more than six hours after the crash, Chuck Espersen was on the telephone, talking to a psychologist on a national radio call-in show. The show was broadcast on KTSM-AM in El Paso.

The psychologist, David Viscott, tried to comfort him as Espersen started sobbing, "That innocent, sweet, poor little child."

"You tried," Viscott said. "If we were all made of such stuff, what a world it would be."

Espersen was still crying an hour after he was on the radio show.

"I kept seeing my son's face," he said.

His son, Lee, 15 had just come home from school and had not heard about his father's efforts.

Espersen sat beside the boy and hugged him as Expersen talked on the phone.

"God, I wanted to save that child," he said. "I need a friend right now."

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INVESTIGATORS CHECK PILOT'S QUALIFICATIONS

Federal Investigators will find out Monday if the pilot of the airplane that crashed Friday was licensed to fly a twin-engine aircraft using instrument navigation.

The pilot, Don McCoy, and two other people were killed in Friday's crash. McCoy was flying under instrumental rules because of low visibility.

Greg Nickerson, a Federal Aviation Administration Investigator from Albuquerque, said records he got from the agency's computer before coming to El Paso Friday afternoon showed that McCoy was licensed only for single-engine aircraft and that he did not hold an instrument rating.

"But he could have had a flight check for those ratings recently, and the paper work could be in the process stage," Nickerson said.

He said such licenses are issued from Oklahoma City and could take up to 90 days to process.

"We'll have to call Monday to find out if they are processing the papers," he said.

Nickerson said investigators will try to determine today whether the landing gear on the plance had malfunctioned, as McCoy had told the control tower at El Paso International Airport a few minutes after the plane took off at about 8:50 a.m. Friday.

McCoy was killed at a time when his company, El Paso Sand Products, was working on a number of high-profile projects in El Paso.

Among recent and current projects were preparation on the site of Sunland Park Mall, now under construction on the West Side; clearing the site of "Star Wars" laser project at Orogrande, N.M.; and work on the reconstruction of Interstate 10.

"He was a very hard-driven man and a very good contractor and was, as far as we were concerned, very nice to work (with)," said Joe Battle, District Engineer with the Texas Department of Highways and Public Transportation.

"He always saw his projects were on time, and he could foresee problems."

Richard Ellison, an engineer with the Department of Highways and Public Transportation, said employees of the department were saddened to hear of McCoy's death because "we think the very world of him."

Ellison said he knew McCoy as someone who "has flown forever. He's always been active in flying."

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Mayor Jonathan Rogers, who said he had known McCoy since 1963, described him as a man who was generous with his money for good causes, but never wanted any publicity.

"He gave $5,000 to the Industrial Development Board," Rogers said. "Any time I was involved with a civic project and I needed money, all I had to do was call Don."

Still, McCoy occasionally was in the news.

In 1985, the company was criticized for preparing substandard asphalt used in a project at El Paso International Airport.

Not long after, McCoy flew, for free, city Reps, Pat Haggerty and Jimmy Goldman to Albuquerque to talk with Federal Aviation Administration Officials about the agency's refusal to approve a paving project at the airport because of questions about El Paso Sand Products.

Both representatives and McCoy said they saw nothing improper about the trip.

McCoy was a member of El Paso Symphony Orchestra Board of Directors and the orchestra's concert Friday night was dedicated to his memory.

INVESTIGATION OF CRASH COULD TAKE 6 MONTHS

Two Federal Investigators arrived in El Paso Friday and began trying to find out why a twin-engine airplane crashed near Interstate 10.

The investigation could take six months, said Tommy McFall of the National Transportation Safety Board Office in Fort Worth.

McFall's agency sent Armond Edwards, an air safety investigator, to El Paso. The Federal Aviation Administration sent Greg Nickerson.

Nickerson will be "looking at the pilot and his proficiency and the aircraft and the weather... to see what type of problems he may have been having," said Ruben Gonzales, acting manager of the Federal Aviation Administration in Albuquerque.

Gonzalez said his agency also will check the plane's navigational equipment and any other air traffic that may have contributed to the accident.

Edwards will examine the wreckage and interview witnesses and the people on duty at El Paso International Airport's Control Tower.

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WITNESSES DESCRIBE 'BIG BALL OF FIRE'

Ana Morales was headed back to her flower shop, Flowers by Ana at 8407 Alameda, from Downtown when the airplane hit Gateway East. "I have a sunroof in my van, and when I looked up, there was just a big ball of fire. It kind of shook my van. It just barely missed me."

She pulled to the side of the freeway. "I started running - so did the guy next to me - to see if we could help. It was just one explosion after another."

Carlos Rosales was on his way to work when he heard the plane overhead.

"What got my attention was the noise. The plane went right over my head heading south. I think there was something wrong with the engine because it was making so much noise... The wings were wobbling back and forth... I saw it go down. It looked like he tried to avoid the freeway - he just went over the tops of cars... Then I heard the explosion."

Rosales said he pulled into a Chevron Station where he learned the attendant was already calling the police.

Rosales, 23, assistant manager of Kettle Restaurant, 6110 Gateway East, was about a half block from the crash site.

Mario Hinojosa, 36, manager of the Kettle Restaurant, went to the scene after he saw the fire and smoke.

He saw a body.

"It just tore him in half," he said.

The plane was disintegrating in the fire. He saw no one else.

At the La Quinta Motel, 6140 Gateway East, Amparo Sambrano also saw the plane go down. Sambrano, a maid, gave an account that conflicts with others: She is certain the plane was on fire before it hit the ground.

"It was coming down in flames, then the explosion. It was terrible," she said. "It was like a big ball of flame. I just started yelling, 'God!, God!"

At the Dental Ceramics Laboratory, 6216 Gateway East, employees got a very close look because the plane came down on the edge of the parking lot next to the building.

Julio Bustamante, 42, who works at the lab, lost his 1977 Cadillac because it was parked near the curb a few feet from the crash and immediately was engulfed in flames.

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"It was burned pretty good," he said. The car had been given to him as a gift by a doctor who had grown too old to drive. Bustamante has no comprehensive insurance to cover the accident.

Bustamante did not seem upset Friday as he calmly worked on a partial upper dental plate.

"That's where I always park it. It was just a matter of luck - pretty bad luck."

Hilda Miranda is a receptionist for Dr. John E. Knudson, a Dentist whose office is across the parking lot from Dental Ceramics Laboratory.

Miranda said flames from the explosion 50 feet away rolled right up to the window at the front of the office, throwing everyone into a panic.

"It shook the whole building, and there was fire everywhere," Miranda said. "Everyone was trying to get out to move their cars. We couldn't tell what it was - a plane or what."

She said a man came into the office, very shaken, to sit down. He told her the plane hit the top of his truck on the freeway before striking the ground and exploding. He said he pulled over and ran back to the wreckage and pulled the body of the boy away.

"He was in the waiting room crying that he and his partner had pulled the burning body of a boy out of the fire."

The man was consoled, she said, by a priest from the nearby St. Pius Church.

"I didn't see the plane or hear it," Chuck Espersen said. "I just saw the flash and then the flames, and I went to help."

Espersen had been at a breakfast meeting and was waiting at a stoplight at Geronimo and Gateway West when the plane crashed.

At the scene, he tried to rescue Jesus Aaron Puentes, 11, who was in the plane. He could not.

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EL PASO TIMES

PROPOSALS GET TOUGH ON DRINKING AND DRIVING

The Senate Judiciary Committee Friday approved two bills aimed at cracking down on drunken drivers, while the House Judiciary Committee approved a similar bill.

Senate Bills 250 and 277 were forwarded to the Senate Finance Committee, where they will join the original drunken driving bill submitted by Gov. Garrey Carruthers, Senate Bill 62.

All three Senate bills contain the same provisions first proposed by the governor in SB62, sponsored by Sen. W.S. "Smitty" Eoff, R-McKinley, and House Bill 62, sponsored by Rep. Mary Thompson, R-Dona Ana.

The House Judiciary Committee approved HB62 Friday, and it now goes to the House Appropriations and Finance Committee.

SB62 and HB62 provide for:

- Impoundment for 30 days a vehicle owned by a person convicted of a second drunken driving offense.
- Impoundment for 60 days a vehicle owned by a person convicted of a third drunken driving offense.
- A mandatory six-month jail sentence and $1,000 fine for a person convicted of a fourth drunken driving offense.
- Mandatory four-day jail sentence and $300 fine for driving without a license previously revoked for drunken driving, or refusal to be tested for blood-alcohol content.

In all the bills, sponsor-supported amendments have removed the original provisions requiring permanent forfeiture of his vehicle upon a fourth or later conviction.

The two Senate bills introduced later contain the same provisions, but add another, sometimes conflicting, provision.

SB250, sponsored by Sen. Larry "Skip" Vernon, R-Bernalillo, makes the fourth offense a fourth-degree felony.

That means a person convicted of a fourth offense would be subject not only to the mandatory six-month county jail sentence but also prosecution in district court that could result in an 18-month prison sentence and a $5,000 fine.

The Legislative Finance Committee estimated it would cost $15 million to incarcerate the additional felons under Vernon's proposal.

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Vernon told the committee that New Mexicans are willing to foot the bill.

SB277, sponsored by Sen. Victor Marshall, R. Bernalillo, would require a repeat offender to attach special, distinctive license plates to his car for one year, the so-called "scarlet letter."

Marshall told the Senate Judiciary Committee that the Legislature should try every possible way to curb drunken driving.

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EL PASO HERALD-POST
by Leticia Zamarripa

FIREFIGHTERS, RESCUE CREWS DISAGREE ON DROWNING

Firefighters and Emergency Medical Service crews today were in disagreement over how EMS crews handled a drowning call Sunday.

Jesus Franco Guevara, 31, was still alive at about 8:00 p.m. when the Fire Department responded to a call at 1800 W. Paisano Drive. EMS crews apparently did not try to revive him when he was pulled out of the water late Sunday evening. He was later declared dead.

Assistant Fire Chief Don Johnson said firefighters would have started cardiopulmonary resuscitation on Guevara, even though he had been under water about 20 minutes. "EMS made a judgment call," Johnson said.

EMS Chief Bill Brown declined to comment on the incident, and said only that he didn't have any problems "with my crews' actions."

Brown referred any further questions to Dr. Michael Wainscott, an assistant professor at Texas Tech University Health Sciences Center in El Paso, who was unavailable for comment this morning.

The drowning was under investigation by the Police Department's Crimes Against Persons' Division, police said.

Guevara, who was swimming across the Mexican side while his wife, Deborah, looked on, got tangled in barbed wire in the canal, police reports show.

"They should have initiated CPR (cardiopulmonary resuscitation)," said a firefighter who was at the scene, but refused to give his name. "We (Fire Department) would have. It's our policy. We are not doctors. We do not pronounce anybody dead."

Kevin Hoban, the EMS supervisor at the scene Sunday, also was unavailable. Blas Mesa, an EMS supervisor, said that EMS personnel don't usually start CPR in cases where there is evidence a person has been in the water for "quite a long time."

He further added that he was not at the Sunday drowning, but that he didn't think 20 minutes was a "long time."

"Normally we would initiate CPR, especially in cold-water drownings," Mesa said.

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EL PASO TIMES
by Amber Smith

PANEL OF MEDICAL EXPERTS CLEARS AMBULANCE WORKERS IN DROWNING

Ambulance technicians didn't try to resuscitate a man they pulled from the Franklin Canal March 2 because he was already dead. The acting director of medical experts, organized to review the drowning, had determined that actions of ambulance workers were appropriate. Firefighters who were called to the scene and tried to save Jesus Franco Guevara complained that the emergency medical technicians, who pulled the man from the water, did not begin lifesaving efforts.

Guevara, 32, of Odessa, Texas, became tangled in barbed wire as he tried to cross a head gate near the 1800 block of West Paisano. Bystanders reported hearing cries for help about 45 minutes before emergency teams were called, police reports stated. It was another 15 to 20 minutes before Guevara was reported to have been pulled from the water. The first firefighter to arrive on the scene dove in to try to save Guevara but was unable to free him from the barbed wire. Ambulance workers, on the opposite side of the head gates, finally were able to pull him from the water.

No firefighters filed complaints against Emergency Medical Services, Assistant Fire Chief Don Johnson said.

The panel of experts included the medical director and the ambulance service chief, two trauma surgeons and an emergency-medicine physician.

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EL PASO TIMES

SARAGOSA VICTIM FIGHTS TOUGH ODDS

Lydia Meneses refuses to believe the medical experts who say her son won't recover from the Saragosa tornado.

"He will, I just know he will. I'll keep on believing that no matter what."

Ramon Meneses, 22, suffered massive head injuries in the May 22 twister. He is now at Pebble Creek Nursing Center, 11608 Scott Simpson in East El Paso, getting physical therapy.

Lydia Meneses said her son was caught in the tornado because he was trying to save his aunt, Ninfa Ontiveros, 45.

He was walking to her house when the tornado picked him up, carried him for more than 100 yards and dropped him on his head.

His aunt was killed.

Ramon is the last hospitalized victim of the tornado, which killed 30 and injured about 180 people. About half the buildings of Saragosa, Texas, a small farming community 190 miles east of El Paso, were destroyed.

The tornado left Ramon in a coma, but Lydia Meneses, 56, said her son has improved in recent months.

"My son opens his eyes and can hear voices and detect movement," she said. "I just know he will get better because he's young and strong."

Maxine Smith, Pebble Creek Nursing Center administrator, said Ramon's prospects for a full recovery are not very good.

She said Ramon still is considered to be comatose, even though he responds to some stimuli.

"I'm sorry to say, and it's sad, but Ramon's mother is just grasping at straws," Smith said. "She's not willing to face the fact that her son will never have a normal life."

But Lydia Meneses counters, "People just don't know my son. He's a strong young man. He was always very athletic, always exercising. He didn't drink, he took good care of himself."

"I just don't believe anybody who tells me my son won't get better. He will, I just know he will. I'll keep on believing that no matter what."

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Lydia Meneses lives in Saragosa but was out of town visiting friends when the tornado struck. Since then, she has been staying near her son as he was transferred from hospital to hospital.

She said her son is making progress not only because he opens his eyes, but because sometimes he gets angry at her, especially when she is massaging his arms and his legs.

"He must be in great pain, or he's trying to tell me something, but only God knows," she said. "He's just like a little boy, helpless. But I can sense his frustration. He makes horrible noises because he can't talk, but to me those horrid sounds are beautiful. They mean he's getting well."

Lydia Meneses said her son used to weigh about 170 pounds, but he went all the way down to 100 pounds. "Now he weighs 126 pounds, and he's getting stronger every day."

Ramon was taken to the Odessa Medical Center after the tornado. July 6, he was transferred to the Institute of Rehabilitation and Research in Houston. He stayed there until December 18, when he was transferred to the Pebble Creek Nursing Center.

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EL PASO TIMES

DOUBTS BENEFITS OF NUTRITION ADVICE

The article, "Let your body cleanse itself: it only takes six days" by Daniel de Winter was based on a nutritionally inadequate five-day meal plan and misleading information. The article promotes the consumption of mainly fruits and vegetables in a five day "detox program." According to the author, raw vegetables and fruits, which contain "loads of vitamins and minerals," will help get rid of toxins while helping burn excess pounds.

This proposed meal plan is inadequate in calories, protein, carbohydrates, B vitamins, folacin, calcium, iron and zinc, which the author assigns special beauty, revitalizing and purifying properties.

The average caloric level of the meal plan suggested by de Winder is between 550-700 calories and 19-25 grams of protein per day. These levels can be harmful to your health. Losing weight with this plan can lead to the breakdown of precious body protein and the loss of body fluids and electrolytes, which may result in dehydration.

Levels of the trace minerals considered by the author as "beauty minerals" are now in the suggested meal plan. These nutrients are found in a variety of foods. A well-balanced meal provides you with all the vitamins and minerals needed daily and, most importantly, adequate calories and protein.

The plan includes five days of detoxification from "toxins such as coffee, alcohol, fats and other beauty no-nos." What about the other 360 days of the year? If you wish to maintain your health and keep fit, you must begin to eat a well-balanced diet, and get adequate exercise and rest every day. Permanent changes in food choice and moderation in your lifestyle are the keys to health.

If you want accurate nutritional information, consult nutrition experts.

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EL PASO TIMES

NATURAL CANCER CAUSERS

Many foods full of carcinogens

Many foods contain very high levels of natural cancer-causing agents, suggesting that intense efforts to control industrial carcinogens may be misplaced, a researcher said Friday.

Apples, for example, contain high levels of formaldehyde, which is considered to be a potent carcinogen, said Bruce Ames, chairman of the biochemistry department of the University of California, Berkeley.

Broccoli contains a substantial amount of substance that is chemically similar to dioxin. Peanut butter is unavoidably contaminated with a fungus that is highly carcinogenic.

"Does that mean we're being done in by vegetables? Well, that's what the reality is turning out to be," Ames said at the annual meeting of the American Association for the Advancement of Science.

Ames said he does not, in fact, believe that the cancer-causing agents in food are causing us harm, because we have evolved to defend ourselves against those agents.

He believes, however, that the defenses we have evolved also protect us against industrial carcinogens, which cause cancer in the same ways as do natural carcinogens.

Peter Preuss, director of the Office of Health and Environmental Assessment at the U.S. Environmental Protection Agency said, "I think there's a great deal of importance in which Professor Ames said."

He was critical, however, of many of Ame's calculations. "While the idea is important, I'm disturbed by the details. I think there's a lot of rigor that has to be introduced into that science before it's accepted."

He noted, for example, that the dioxin-like substance in broccoli might act differently than dioxin. "There are a lot of things that are like that, but, nevertheless, dioxin is unique," he said.

Ames said most of the natural carcinogens in plants evolved as a natural defense mechanism.

"Plants don't have teeth, they don't have claws, and they can't run away," he said. "All plant evolution is plants developing new and better toxins to fight off predators."

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Ames began his talk by saying that the world is full of carcinogens but that they are not as harmful as people believe.

One line of evidence is support that, he said, with a few exceptions, rates of cancer have not increased in the industrial era.

"Except for lung cancer, which is due to cigarette smoking, rates of cancer are staying steady or going down," he said.

"DOES THAT MEAN WE'RE BEING DONE IN BY VEGETABLES? WELL, THAT'S WHAT THE REALITY IS TURNING OUT TO BE."

While that is true for some cancers, Preuss said, others have gone up. They include melanoma, lymphoma and cancer of the testes, prostate and kidney.

Ames was critical of the use of rats and mice to test whether substances are carcinogenic.

"It's reasonable to think that chemicals that are carcinogens in mice and rats would be carcinogens in people - but the hook is, at that dose."

Rats are given the maximum dose that won't poison them, he said, but such doses can kill cells in the body and may lead to cancer simply through the disruption they cause. If that were the case, the substances would not be expected to cause cancer at the low doses that humans might be exposed to, he said.

Ames is the developer of an alternative test that uses bacteria to identify possible carcinogens.

Ames presented dozens of examples of carcinogens in plants. Celery contains psoralens, which become carcinogenic when exposed to light.

Potatoes have high levels of solanine and chaconine, which block an enzyme called cholinesterase, he said. Organophosphate pesticides are considered dangerous, he said, because they do the same.

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EL PASO HERALD POST

ONE IN THREE HISPANICS RISKS HYPERTENSION

Doctors says Latinos' and Blacks' odds for heart attacks greater..

One in three Hispanic adults has high blood pressure, says Dr. Ramon Rodriguez-Torres.

Rodriguez-Torres of Miami, Fla., is on a lecture tour, taking his message across the country.

The message is that studies show Hispanics and Blacks are at higher risk than Anglos for heart attack, stroke and kidney failure, because of hypertension. And, Rodriguez-Torres says, the risk can be greatly reduced with simple treatment.

The doctor will be in El Paso March 25 to address the Southwest Association of Hispanic-American Physicians and the Inter-American College of Physicians and Surgeons.

He contends that dietary, and possibly hereditary, factors contribute to higher incidence of hypertension among Hispanics.

Further, he says, studies indicate that most Hispanics with hypertension are unaware of the fact.

Hypertension - or high blood pressure - is discovered by measuring blood pressure. The measurement tells the difference between the force the heart uses to push blood through the arteries and the resistance of the arterial walls. Hypertension means high pressure in the arteries.

Rodriguez-Torres, a cardiologist and pediatrician, believes a salt - and fat-heavy diet is the culprit in the higher incidence of heart disease among Hispanics who have their blood pressure checked regularly.

He says cutting salts and fats is the first step in a program to reduce high blood pressure.

If that doesn't do enough, then he urges doctors to prescribe a diuretic - but not any diuretic, only one that does not deplete the body of potassium.

Diurretics eliminate salt and fluids from the body.

However, those that also deplete the body of potassium - a mineral essential to maintaining the body's electrolite levels - may cause heart problems.

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If the blood pressure still does not come down adequately, then Rodriguez-Torres recommends traditional blood-pressure medications such as alpha and beta blockers, vasodilators and calcium channel blockers.

However, he says, studies indicate dietary changes and daily use of diuretics reduce high blood pressure for 75 percent of patients treated. Rodriguez-Torres' lecture tour is being underwritten by Lederle Laboratories which manufactures Maxzide, a diuretic combining tramterene and hydrocholorothiazide.

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EL PASO TIMES
March 26, 1988

HISPANIC AMERICANS AT GREATER RISK FOR HIGH BLOOD PRESSURE

Hispanic Americans are more likely to have high blood pressure, and they're less likely to know it than their Anglo counterparts, a cardiology specialist said Friday.

Dr. Ramon Rodriguez-Torres, chief of staff at Miami Children's Hospital, was in El Paso to address the Southwest Association of Hispanic-American Physicians and the Interamerican College of Physicians and Surgeons at a dinner lecture at the Coronado Country Club.

High sodium, in the Hispanic American's diet and a genetic predisposition seem to be the primary culprits behind the problem, said Rodriguez-Torres, a Cuban-born Pediatrician and Cardiologist.

Studies show that heart disease is a major cause of death among the 18 million Hispanic Americans, and high blood pressure is their No. 3 health problem.

Less than half of all Hispanic Americans with high blood pressure know they have the problem, and only one in five is under treatment for it, according to the Hispanic Health and Nutrition Examination Survey.

A study done by the National Heart, Blood and Lung Institute from 1976 to 1980 showed that 28.7 percent of adult Hispanic Americans had hypertension.

"The most important message I want to get out when I do these lectures is to tell the Hispanic American population, 'Get your blood pressure checked once a year. Know your blood pressure,'" Rodriguez-Torres said.

Two kinds of high blood pressure exist: the type that is a result of some other disease or ailment, and that type whose cause is unknown. Rodriguez-Torres said 90 percent of all adult cases of hypertension fall in the second category. "The person may feel perfectly healthy and have high blood pressure," he said. "We don't know what causes it."

The disease is made more dangerous by the fact that the victim suffers no symptoms. "This is the worst of it," Rodriguez-Torres said. "Unless you need to know what your blood pressure is, you won't know until much later, when the damage has been done."

EL PASO TIMES

NEW HEART PUMP ON HORIZON

Texas team develops device for surgery.

A new heart pump that may improve the survival and recovery rates of open-heart surgery patients is the brainchild of a former Tyler man and his medical colleagues at the University of Texas at Austin.

It has been 17 years since the development of the Runge-Bohls, or the UT, external pulsatile pump and valves started. There are now realistic hopes that the pump will be certified by the Food and Drug Administration in early 1988 and will be made available for testing in research and treatment by 1990.

By the mid-1990s, the pump may be the primary piece of equipment used by surgical teams to provide blood and oxygen to the body while patients are undergoing openheart and bypass surgery. The pump also may be used to help restore the heartbeat of victims of cardiac arrest or support heart action for other patients.

Dr. Fred Bohls is one of the two men directly responsible for the new heart pump. Bohls, formerly of Tyler, and Dr. Tom Runge, UT-Austin professor and heart specialist, have provided the creativity and tenacity in seeing the need, finding a solution and making improvements in the new technology.

Runge, graduate students and pre-med students at the UT-Austin biomedical engineering department have made and improved the series of valves and pumps.

Current pumps provide a steady flow of blood, while the UT-pump is designed to stimulate the pulsing of the heart. Tests at the Texas Heart Institute in Houston, the San Antonio branch of the UT Medical School and the University of Michigan have compared the two systems. In the process, the Runge-Bohls Pump has attracted the interest of the American Medical Association as it has been demonstrated at medical conventions and other professional meetings.

In a Dallas demonstration, surgery was performed on six dogs, with only one of the six dying. "The other system used nine dogs with five deaths resulting," Bohls said.

"In the Runge-Bohls pulsating pump, there is only minor pressure on blood cells. That makes it possible to avoid most of the breaking down of the vari-shaped blood cells as they are pushed through a sac by the pulsatile pump and through the valves, which cause very little pressure on the blood cells. Use of the traditional roller-style, continuous-flow pump crushes and damages many of the blood cells as they are forced through the roller," Bohls said.

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By John Laird

VOLUNTEER TAKES LITTLE FOR GRANTED

For 67 years Harrison Kohl took his heart for granted.

As often happens in such cases, the neglected party grew tired of serving. On the last day of 1980, Kohl's heart rebelled with an unremitting pain.

He spent the first nine days of 1981 in a hospital, recovering from a quadruple bypass.

Six and a half years later, Kohl doesn't need the American Heart Association to tell him that February is "Heart Month." Every month is special for a man who no longer takes his heart for granted.

"I'm in much better shape now," he said, mixing unabashed pride with a lingering sense of reality about cardiovascular diseases. Kohl is one of the most active volunteers in the El Paso Chapter of the American Heart Association. "I had known about the angina (decreased blood supply to the heart) because I'd had chest pains for quite some time. But on New Year's Eve of 1980, the pills I took didn't stop the chest pains. I was watching the Bluebonnet Bowl on TV, and I knew something was wrong. I told my wife to get me to the hospital immediately."

Kohl was lucky. He was back on the putting green in five weeks. Six weeks after his surgery he played nine holes at Dos Lagos Golf Course, "but I only used a 5-iron and a putter." Nine weeks after the operation, he armed himself with a full quiver of clubs and walked 18 holes.

Kohl was back. So was his heart. "I had no choice. If there hadn't been the surgery, I wouldn't have made it," Kohl said. "Dr. (Joe) Kidd and Dr. (Felice) Bruno did a great job of saving my life."

Now, Kohl walks four to six miles every morning and plays golf about three times a week. He is retired professionally. But he spends several hours a week helping the American Heart Association's fund-raising events and educational programs. He also works with the Mended Hearts Association, which includes people who have had heart surgery. "The Mended Hearts motto is It's great to be alive and help others." "That's the way I feel," Kohl said.

Helping others includes frequent hospital visits. Kohl counsels heart paitents, and he has no problem getting their attention.

"When I tell them what I've been through, they're ready to listen," he said. "They always enjoy hearing an encouraging word, and I certainly can do that. I mean, look at me. How much more fortunate can you be? I've known the same pain they feel, but they can be optimistic, too."

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According to American Heart Association figures, cardiovascular diseases are responsible for 43 percent of adult deaths in the United States. In El Paso, the rate is about 40 percent. Other statistics in Texas include San Antonio (42.2 percent), Lubbock (45.6 percent) and Dallas (43.5 percent). But the American Heart Association in El Paso is increasing its efforts to educate the general public about the heart's greatest enemies: improper diet, smoking and lack of exercise.

Kohl said recovery "always is longer than anyone would want. You have to work hard in rehab, and you have to be very patient. But the final goal is reachable, and it's worth all the work."

Kohl worked for several years until 1974 as executive director of the Sun Bowl Association. Now, though, he is equally enthusiastic about his work with the Heart Association. "I'm glad to see more awareness about heart issues and health, but I wish more people knew about the dangers, and did not give up during recovery."

Kohl cited another risk factor that, in his opinion, is a greater cause of heart disease than improper diet, smoking or lack of exercise. "And it's something people can control, if they only would."

Kohl speaks of stress. "Pressure kills people. It almost killed me. If more people only knew how much pressure hurts them. My attitude is: If you didn't break it, it's not your fault. Don't worry about it."

"Much of today's stress is a result of a growing technology," Kohl said.

"Younger people these days have so much more pressure in their lives because of high-tech living. It really worries me."

"But not enough to interfere with tomorrow's tee time."

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EL PASO TIMES
April 14, 1987
by John Laird

HEALTH BOARD WANTS TO DOUBLE AMBULANCE SERVICE BUDGET

El Paso's Emergency Medical Services will more than double its budget in 1987-88, if the City-County Board of Health has its way.

The budget, approved by the Health Board Wednesday, will be submitted to City Council for budget hearings in July or August, City-County Health District Director Dr. Laurance Nickey said.

The new figures show an increase in the ambulance service's total budget to $5.8 million from $2.8 million, in 1987-88. If the full budget is approved by City Council, the number of emergency stations would increase from nine full-time and one half-time stations. Twelve ambulances would be added to the current fleet of 17, and the Emergency Medical Services staff would increase to 162 from 107 employees.

Emergency Medical Services Chief Bill Brown said the new budget includes a "basic budget" of $2.8 million, a "budget supplement" of $1.6 million and an "informational supplement" of $1.4 million.

The supplements were requested by Dr. Gary Ryan, chairman of the Health Board. Ryan said, "I asked (Brown) to submit whatever budget is necessary to upgrade EMS to what is needed. Instead of screwing around for five or six years, we need to bring EMS up to the quality of service that is necessary."

Brown said, "Austin has a slightly smaller population than El Paso, but they've got a $7 million emergency medical budget. We've got much stronger service requirements than Austin."

The 12-part supplemental budget includes an additional $370,000 for transition of Emergency Medical Services from the City-County Health District to a separate department of the City of El Paso.

El Paso's 10th emergency medical station already is scheduled to open at El Paso International Airport in July. The informational supplement to the budget projects five additional stations in the next five years, tentatively scheduled for the Northeast, the West Side, near Alameda and Lafayette Street, near Zaragoza and Interstate 10, and near Ascarate Park.

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EL PASO HEARLD POST
January 13, 1987
By Julian Resendiz

EL PASOANS OPPOSE MOVING HEALTH OFFICE

About 20 El Pasoans voiced their disapproval today of a plan that would move the regional office of the Texas Health Department out of the city.

A proposal under consideration by the Texas Department of Health calls for the expansion of Public Health Region 3, which now incorporates El Paso, eastward to Midland.

"The proposal, which will be considered by the Texas State Board of Health on January 31, calls for most of the El Paso staff to be transferred to a new headquarters in Midland," Carl Welge, Assistant State Commissioner of the Board of Health, said.

The restructuring, Welge said, comes as the result of efforts by the state to cut down on administrative costs in state agencies. The number of administrative regions would be reduced from twelve to seven, with six sub-offices being created, including one for El Paso.

Twenty-one employees would remain in El Paso at that sub-office, while about 30 employees would be transferred to Midland.

Many El Pasoans present at the Board of Health Public hearing today said they don't see any benefit in moving the headquarters.

"There are a lot more people here than in the areas around Midland. Why move away from the population centers?" said El Pasoan Walt Morris.

Morris and others said most people in the city are opposed to the plan.

"There are inconsistencies in the way you're trying to centralize these new headquarters," said David Thomas. Dr. Laurance H. Nickey, Director of The El Paso County Health District, also voiced opposition, but suggested the possibility of having the county health district manage the remaining sub-office positions.

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EL PASO TIMES
by Amber Smith

EMERGENCY ROOMS SHUT DOORS TO PATIENTS

Some ambulances sent hunting for hospital

Critical-care patients sometimes spend precious minutes in city ambulances while paramedics try to find an open El Paso hospital emergency room.

Four hospitals in El Paso close their emergency rooms frequently to Emergency Medical Services' ambulances for periods ranging from an hour to several hours because critical-care beds are filled or the hospitals don't have enough nurses to watch over them.

At Providence Memorial Hospital, Dr. Rusty Thamarus, Director of the Emergency Room, said, "When we have a patient from the Lower Valley who goes by Vista Hills, goes by Thomason, goes by Hotel Dieu and goes by Sun Towers to come here, you sometimes wonder what is going on."

But patients who arrive in private vehicles or private ambulances still are accepted at the hospitals that have closed their emergency rooms.

"It's kind of ironic," said Dr. Paul Navar, Director of Sierra Medical Center's Emergency Room. "If a patient walks in, by law, the emergency room staff is required to see him. But if you call the (city) ambulance to transport you to the hospital the emergency room will be closed."

The closure policy at Southwestern General Hospital is an example: "If we feel that we cannot offer quality care, if we feel we do not have enough nurses, we will close," Brenda Lucero, Director of Nursing, said.

This has created concern among medical professionals who are asking themselves what to do in the event the closest hospital emergency room is packed.

Emergency Medical Services Chief Bill Brown said, "The issue here is that we don't have enough critical-care beds. We don't have enough nurses. The hospitals are swamped."

Dr. Brian Nelson of Thomason Hospital said critically ill patients "usually require, if things go well in the first two hours, skilled nursing care at a very intense level for a long period of time, and such nursing care is at a shortage in this city."

Four of El Paso's hospitals that receive Emergency Medical Services patients closed their emergency rooms at different times October 3. At least two patients felt the effects.

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An ambulance carrying a 22-year-old man with a gunshot wound in the forehead was on route to Vista Hills at 7:45 p.m., when the hospital informed paramedics the emergency room was being closed. The man, picked up in the 200 block of South Ascarate, was rerouted to Sierra.

Vista Hills then closed its doors to Emergency Medical Services' patients at 7:58 p.m. and didn't reopen until after midnight, according to Emergency Medical Services' records. The same hospital's emergency room had been closed from 6:55 to 10:41 a.m. and again from 11:58 to 1:45 p.m.

Thomason's emergency room was closed all day.

Sun Towers closes its emergency room doors from about midnight until 7:24 p.m.

Earlier in the day, an ambulance was called to transport a 24-year-old man who said he was hearing voices and wanted to kill somebody. Because Thomason was closed, the paramedics headed for Providence but officials there said they couldn't take the man because they had no psychiatrist on duty. The man was taken to Sierra and later by police car to Thomason.

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EL PASO TIMES

IT MAY NOT BE TOO LATE TO SUE OVER MISHAP

Question: I had an accident in a hospital and was wondering if there is a statute of limitations for filing a lawsuit. After surgery I was allowed to dress myself before the anesthesia had worn off. I fell back against the wall while trying to put my trousers on, injuring my head and neck. My $350 watch broke into pieces, and I also felt burning in my groin, which turned out to be a hernia. I was 70-years-old at the time, and it was my first visit to a hospital.

— J.E. Valenzuela, Lower Valley, El Paso

Answer: Statutes of limitation vary depending on the nature of the suit, but usually range from one to four years. The type of action you would take probably has a two-year limit, but see a lawyer. The date you first discover a serious injury, not when the accident happened, sometimes makes a difference.

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NEWSPAPER ARTICLE

DEATH IN FAT-REMOVAL SURGERY BLAMED ON MASSIVE INFECTION

A woman who died after fat-removal surgery was killed by a massive infection, the Harris County Medical Examiner's office has ruled.

Patsy Howell, 39, died March 30, three days after undergoing the procedure at the office-clinic of Dr. Hugo Ramirez in Pasadena. A second woman, Patricia Rogers, 31, underwent the same surgery the same day at the clinic. She also developed an infection and was listed in stable condition at St. Luke's Episcopal Hospital.

April 3, the executive committee of the Texas Board of Medical Examiners temporarily suspended Ramirez's license pending investigation.

Ramirez has said the complications developed by the two women were part of the risk of the surgery and could have developed whether the surgery was performed in an office or a hospital.

Howell's husband and her two sons are pursuing separate lawsuits against Ramirez.

Friday, the medical examiner said he ruled that Patsy Howell died as a result of septicemia and peritonitis after liposuction, or fat-removal surgery. Septicemia indicates circulating bacteria in the bloodstream, which in some cases can overwhelm the body's defenses and cause death.

Peritonitis is an acute inflammation of the membrane lining the abdominal cavity covering the major organs there.

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NEWSPAPER ARTICLE

EYE TECH IS HIGH TECH

Research focuses on new solutions to old problems

From lasers to super glue, the trend in eye tech is high tech, researchers at a seminar said this week. But researchers also are finding new uses for not-so-new tools, they reported.

A camera fitted with a special lens may help diagnose children who suffer from crossed eyes or amblyopia, a defect sometimes referred to as lazy eye, said researcher Dr. Susan Day, a pediatrician of a Medical Center in San Francisco.

Used to photograph infants only a few days old, the lens can take a picture that shows a tendency toward crossed eyes, nearsightedness, farsightedness and even cataracts. That means therapies that already are in place can be started early enough to be more effective. Since vision is established by age 7 or 8, the traditional screening of a child's eyes at 5 is too late for optimum treatment, Day said. Since infants cannot read or communicate, there hasn't been a means to detect developing eye problems earlier. The photographic equipment would cost a pediatrician between $300 and $500.

On the other hand of the spectrum is the discovery that a new type of super glue allows surgeons to glue back detached retinas. Dr. Brooks McCuen of Duke University in Durham, N.C., said the medical grade tissue glue still is experimental, but it could mean that 2,500 people each year who cannot be treated by conventional surgery still may have hope. Not only does the glue mend holes and rips in the retina, but it also does not seem to add to visual impairment.

In 50 percent of the cases studied, vision improved significantly. Other advances:

a) Injectible lenses - Scientists at the University of Utah School of Medicine are experimenting with liquid plastic that can be injected into the lens sac of the eye. The liquid sets, providing a new lens for the one removed due to injury or cataracts.

b) Electric injections - Using an electrical current may be the means of driving a sufficient amount of medicine into needed portions of the eye when bacterial infection sets in, said Dr. Jules Baum of Tufts University in Boston. The method is inexpensive, simple, and painless, and after the first treatment it can be done on an outpatient basis.

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c) Regenerating the optic nerve - Researchers have found that transplanting proteins from a goldfish into the damaged nerve of a rabbit triggered some regenerating activity. Sansor Sharma from New York Medical College at Valhalla said this is a step toward the development of regenerating nerves in humans. This holds promise for paraplegics as well.

d) Excimer lasers-Superspeed ultraviolet lasers may be used in surgery on the eye in the near future, said Dr. Carmen Puliafito of Harvard Medical School.

1. 6,400,000 new cases of eye disease are diagnosed each year.

2. 11,400,000 people have impaired vision that cannot be corrected with glasses.

3. 1,110,000 people annually are hospitalized for eye surgery or medical treatment.

4. 500.000 people are legally blind.

5. 34 million visits are made to eye doctors every year.

6. 100 million people in the United States wear some type of corrective lens.

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NEWSPAPER ARTICLE

DRUGS OR SURGERY

Study finds both on par for heart patients

Coronary bypass operations and drugs are apparently equally effective in preventing heart attacks or increasing overall survival for severe chest pain patients, according to a study.

Government researchers reported today that, except in the worst cases, they found the overall two-year survival rates of patients with a serious form of chest pain known as unstable angina pectoris was about the same if they underwent surgery or only took drugs.

"We conclude that patients with unstable angina pectoris have a similar outcome after two years whether they receive medical therapy alone or coronary bypass surgery plus medical therapy," the doctors wrote in the New England Journal of Medicine.

However, the study found that those whose heart-pumping capacity was reduced because of coronary artery disease - about 38 percent of the patients had much better chances of surviving if they underwent the surgery.

About 4 million Americans are estimated to suffer from the chest pain of angina and about half of those patient's conditions can be expected to become unstable at some point. More than 200,000 bypass operations are performed each year in the United States.

The study involved 468 men with unstable angina pectoris, which is chest pain that occurs without warning and usually is a sign the patient is at high risk for a heart attack or sudden death.

The pain occurs because of insufficient blood flow to the heart. This is most commonly due to arteosclerosis or hardening of the arteries, in which the heart arteries have become narrowed by fatty deposits on the arterial walls.

The condition is treated either with a variety of drugs or with bypass surgery. The surgery entails taking an artery from another part of the body, usually the leg, and using it to bypass clogging arteries feeding the heart.

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EL PASO TIMES

HOSPITAL NAMED FOR PIONEERING ARMY SURGEON

There probably are few El Pasoans, outside the medical profession, who know anything about the man for whom William Beaumont Army Medical Center was named and the reason why he deserved the recognition. It's a strange story, one of turning an individual's near-fatal misfortune into a great contribution to the accumulated knowledge of medicine.

William Beaumont was born in Connecticut in 1785, but left his farm home to settle in Champlain, N.Y., where he read borrowed medical books and taught school for three years. In 1810, he became an apprentice to a Vermont physician and two years later received his license to practice medicine. He enlisted in the Army during the War of 1812, continuing to serve as a surgeon's mate until he resigned in 1815. After some years of struggling with private practice, he re-entered the Army in 1820 and was assigned as post surgeon at Fort Mackinac, now in Michigan. He continued in the Army until 1839, when he again retired to set up a general practice in St. Louis.

He acquired a solid surgical reputation in the service, and on June 6, 1822, he was summoned to treat a man named Alexis St. Martin, a 19-year-old French-Canadian trapper who had been wounded at close range by a shotgun blast. The near-fatal shot had torn away much of his stomach and chest. After a year's treatment, he did recover. But the injury had left him with an open window into his stomach that never would heal, and the doctor found he could look through that window and view the activities occuring on the other side.

Another less dedicated person might have gone his way after St. Martin's recovery. Beaumont realized that for the first time ever, it would be possible to make a real study of the human digestive process. He took the victim into his home, where he could continue the study, and made many experiments between 1825 and 1833 at several different Army posts, often hampered by a lack of suitable equipment. There was another and more serious problem. From time to time, St. Martin, tired of being a medical laboratory, would just disappear for varying periods of time... probably on an extended drunk.

Beaumont believed the digestive process was essentially a chemical process carried out by chemicals in the stomach. Determined to prove his theory, he collected samples of St. Martin's gastric juice and sent them for analysis to several chemists, all of whom supported his claim. His report on the findings was published in 1833 and included a study of the effects of different foods going through digestion, throwing an entirely new light upon the nature of gastric juices. The doctor also made an important finding from working with St. Martin. He established that alcohol is a cause of gastritis.

That is the man chosen for the honor of having the El Paso Army Hospital named after him, a well-deserved honor and a distinct credit to whomever was responsible for the selection. Beaumont died in St. Louis in 1853.

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NEWSPAPER ARTICLE

OH, THAT ACHING BACK

How to know when it's time to visit a doctor

After 10 weeks and seven additional pounds, the sports enthusiast is finally playing tennis again. What happened to the summer - and to his waistline? "My back went out," he said, "and all I could do was lie around and eat."

A woman who normally swims half a mile daily was laid up with an ailing back while on vacation in Maine.

I, too, have had to ease up on running because of recurrent back pain, which began, ironically, after my first attempt at an exercise video for beginners.

It seems as if an epidemic of back disorders, ranging from muscle strains to slipped disks and pressure on the sciatic nerve, has struck the exercise enthusiasts I know. And we are hardly alone. Persistent sciatica curtailed a promising tennis career for Tracy Austin. John Davidson, a former goalie for the New York Rangers, spent weeks in traction to ease his crippling attack of sciatica.

Many physically active people don't take back injuries very graciously. Unless they are incapacitated by painful muscle spasms, few take these injuries lying down, a fact that can aggravate the damage.

Back trouble can strike almost anyone at almost any time. While weight-lifters might be particularly vulnerable, you can hurt your back merely by picking up a napkin. Exercise does offer protection, by strengthening the muscles that support the back and reducing the layers of body fat that strain the back. But many of the most popular forms of exercise - such as running and tennis - do little, if anything, to strengthen the back's most critical source of support: the abdominal muscles.

Furthermore, many people pursue the same activity day after day, and gradually add to the stress in vulnerable areas. And few sports' enthusiasts, myself included, take time to do adequate stretching and warm-ups before asking their bodies to perform full-tilt. Only 5 to 10 percent of back injuries involve the disks, cylinders of collagen that act as cushions between the vertebrae. When a disk slips or herniates, in medical parlance - part or all of it bulges out from its usual setting between the bones. The resulting protrusion might cause little or no discomfort, or it might press on the root of the sciatic nerve, causing pain, numbness or muscular weakness anywhere from the middle of the buttocks to the bottom of the foot. The latter condition, known as sciatica, is often but not always caused by disk disease.

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The existence of medically proven disk disease does not necessarily mean that surgery is the only answer, or even the best answer. The vast majority of disk problems - most experts say 90 percent - respond well to conservative treatments: a program of backstrengthening and stretching exercise and lessons in how to bend, lift, sit and stand to avoid undue stress on the back.

Today, most experts recommend cold packs rather than heat to reduce the pain of back-muscle strain and to help break up the muscle spasm. Immediately after the injury, wrapped ice packs should be applied to the area for 10 to 20 minutes at a time over a period of 48 hours, according to Dr. William Southmayd, author of "Sports Health: The Complete Book of Athletic Injuries." But Southmayd still uses heat as a treatment for a sudden attack of disk disease.

Most experts say any of the following conditions surrounding back pain warrant a medical visit:

a) When the pain is severe and disabling and is not relieved by rest and an over-the-counter analgesic like aspirin, acetaminophen or ibuprofen.

b) When back pain is accompanied by pain that shoots down the legs, by numbness or weakness of the leg or foot, or by the loss of bladder or bowel control or difficulty in urinating.

c) When you also have fever, nausea or vomiting, or pain upon urination.

d) When the pain wakes you up at night or prevents you from doing anything at all.

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NEWSPAPER ARTICLE

OH, THAT ACHING BACK

Exercise, precautions are keys to better future

For active people, the most depressing aspect of back pain is probably the realization that a favorite form of exercise will have to be abandoned, at least temporarily. Many activities can add insult to an already injured back.

That's the bad news. The good news is that activities can be modified to spare your back, or can be replaced by activities that might even strengthen your back.

Furthermore, even though your back might hurt now when you attempt your favorite sport, chances are that by doing a 10-minute exercise routine every day to strengthen and stretch your back, and by adopting back-protecting habits, you can soon resume your usual activities without pain or risk.

Orthopedists usually advise back-pain sufferers with medically established disk disease or a herniated, or "slipped" disk, or a degenerated disk to avoid sports that put severe stress on the back, even after the pain of an acute attack is but a dim memory. Dr. Willaim Southmayd, an orthopedic surgeon and the medical director of Sports Medicine Resource in Boston, said that in general people are better off staying active.

Most important when a back flares up is to give it adequate time to heal. Southmayd's recommendations for treating back pain include staying bed for 48 hours and taking muscle-relaxing pills if they have been medically prescribed.

But as soon as you can do so comfortably, you would be wise to start special daily exercises. Following are the most frequently recommended exercises:

a) Strengthen your abdomen by doing bent leg sit-ups. Lie on your back with knees bent and gradually return to starting position, then repeat without resting in between. Gradually work up to three to five sets of ten.

b) Strengthen buttocks muscles and reduce the curve in lower back by doing the pelvic tilt. Lie on your back with knees bent, flatten it and simultaneously raise your hips, tightening the muscles in the buttocks and thighs. Hold for a count of 10, return to starting position for a count of 5, then repeat. Work up to 20 sets.

c) Stretch the back muscles by sitting on the floor with knees straight and legs as far apart as possible. Place both hands on the same knee and gradually move the hands toward your foot, going no farther than is comfortable. Hold this position for 10 seconds and then slowly release. Do 10 repeats; then do the same over the other leg.

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Equally important is learning how to perform ordinary movements so that you don't strain your back. Here are some suggestions:

d) Never bend from the waist only. Lower your upper body by bending from your knees and hips.

e) To lift a heavy-object, bend from the knees to reach it, hold it close to your body and then stand up by straightening your knees. Do not try to lift heavy loads above your waist.

f) Balance the weight of what you carry between both hands or shoulders.

g) Avoid sitting on soft chairs and deep couches. Sit with a firm support for your back and with your knees higher than your hips.

h) If you must do jobs that involve prolonged standing, place a footrest under one foot. This will help to straighten your back and reduce strain on lower back muscles.

i) Avoid sleeping on your stomach. Sleep on your back with a soft pillow under your head and with two pillows or a blanket roll under your knees, or sleep on your side with knees bent in the fetal position.

j) Wear flat shoes or shoes with moderate heels. Women should avoid heels higher than one and a half inches and should especially avoid repeatedly switching from high to low heels.

NEWSPAPER ARTICLE

SCIENTISTS SEEK CURE FOR PARALYSIS

It used to be that when your spinal cord was injured, you were sentenced to life in a wheelchair... Or worse.

But armed with promising new medical findings, a growing number of doctors, scientists and paralysis victims are refusing to accept that verdict. Their goals: to cure paralysis.

At the crux of their new-found hope are recent discoveries that question the long-held theory that a nerve cell, once injured, cannot be repaired.

Experiments now show nerve tissue can be transplanted or regenerated, that gaps in the communications system between nerve cells can be jumped electrically, and that a person who suffers a spinal cord or brain injury need not be doomed to a life of paralysis.

"In ten years we're going to be treating spinal injuries like gunshot wounds as an emergency," said Dr. Harry Goldsmith, adjunct professor of neurosurgery at the Boston University School of Medicine.

Most spinal cord injuries are incomplete; the cord is crushed or bruised but not totally severed. That means some nerve cells are left alive in the area of injury, even if they are damaged. Therein lies the thread of hope on which the latest research hangs.

"Fifteen years ago we would have painted a very bleak picture of their capacity for regrowth," said Dr. Bradfor Stokes, co-director of the Spinal Cord Injury Research Center at Ohio State University.

But recently, it has been found that the marginally injured cells are capable of resprouting. Scientists are looking for ways to direct the growth so that functions may return.

"Regeneration and sprouting of damaged spinal cord nerve cells appear to hold the best biological hope for conquering paralysis," a research report by the National Institutes of Health said.

But that's not to say a cure is imminent. Scientists painstakingly warn that their success cannot be interpreted yet as a solution for paralyzed patients.

"I don't want to fly a flag that says there's a cure around the corner," Dr. Paul Reier of the University of Florida said.

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Spinal cord injury repair experiments still are limited to animals - mostly rats - and the leap from them to humans is a broad one. While findings indicate - damaged nerve cells might be repaired or retrained, no one knows if the re-ennervated tissue can be made to work again.

Nerve cells, or neurons, send the messages for movement to the body's muscle cells. A neuron consists of a cell body with a nucleus, branches called axons that carry messages from one neuron to another or from an neuron to a muscle cell, and fine branches called dendrites.

If the neuron's cell body is destroyed, the cell dies. But the hope for a cure to paralysis lies in the recent finding that damaged axons do not doom the cell to death. So researchers are trying to find ways to restore function to damaged axons.

In Reier's lab, for example, lesions in a rat's spinal cord are filled with pieces of transplanted embryonic rat spinal cord, and the damaged nerve fiber is induced to grow, something scientists believed could not happen.

"I'm excited. I've seen in 10 years quite a change in scientific attitudes," Reier said.

Dr. Albert Aguayo, neurology professor at McGill University and head of the neurosciences unit at Montreal General Hospital, is a pioneer in implanting what is called a peripheral nerve bridge into a damaged spinal cord or brain, stimulating the regrowth of the long fibers that connect neurons with one another. Tests show that almost normal nerve impulses travel along the regrown axons.

Aguayo transplanted peripheral nerves like those found in the skin (not the brain or spinal cord) into the brains of rats, and the axons regenerated connecting themselves to healthy nerve tissue in the brain.

His work "changed the central dogma" that the central nervous system can't regenerate, said Dr. Richard Borgens, a Purdue University researcher who is stimulating regrowth of damaged nerve cells electronically.

Borgens' research team implanted batteries and ran tiny conductors under the skin near the partially severed spinal cords of guinea pigs. After a current was passed through the leads for several days, the severed fibers began to regenerate and grow through these bridges toward the target nerve cells.

Borgans is experimenting with the technique to see how it affects old injuries, and he is testing whether regenerated never cells can function.

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EL PASO TIMES
April 1, 1988

THINK YOU'RE SAFE? AGENCY TALLIES EVERYDAY HAZARDS

When the U.S. Consumer Product Safety Commission recently demanded the recall of an electric device that zaps worms for fishermen, it noted that 23 people had been killed by similar "worm probes" since 1971.

Who came up with that number?

The statistic - and thousands of others - comes from the commission's National Injury Information Clearinghouse, a group of happy-looking federal employees who spend their days tracking the horrid things that happen to consumers.

The Clearinghouse is responsible for collecting and sharing information on most consumer products - about 10,000 director Joel Friedman estimates - although a few are specifically not within its jurisdiction, such as cigarettes, automobiles and pesticides.

"Everything in this office we have jurisdiction over - lamps, carpeting, desks, insulation, windows," said Friedman, looking around his modest, paper-cluttered room in a Bethesda, Md., office building.

But, "if you're driving a car and hit a tree and die, we wouldn't be interested because it's not under our jurisdiction."

Information comes from several sources. More than 60 hospitals with emergency departments are paid to send information every day about injuries associated with consumer products. That National Electronic Injury Surveillance System is used to draw up estimates of the number and severity of injuries and to find victims for follow-up interviews.

Other information comes from death certificates bought from state health departments, telephone or written consumer complaints received by the commission, and newspaper clippings.

"The Clearinghouse's information is available to the public at a charge. General product information is readily available; information on specific trade or brand names may take months to receive," Friedman said.

"About 6,000 information requests come to the clearinghouse each year. The largest number - about a third of the total - are made by lawyers working on consumer product injury cases," Friedman said.

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HOUSEPLANTS, SHOES AND OTHER DANGERS

Estimated U.S. injuries associated with some consumer products in 1986:

a) Refrigerators, 24,558

b) Tie, belt or other clothes racks, 6,682

c) Toothpicks or hors d'oeuvres picks, 7,269

d) Rope or string, 14,996

e) Cardboard products, 13,232

f) Aquariums or accessories, 5,524

g) Bleachers, 16,703

h) Garden hoses, nozzles or sprinklers, 12,423

i) Footwear, 61,862

j) Desk supplies, 10,331

k) Houseplants, 1,943

l) Manicuring devices, 1,617

m) Nails, screws, carpet tacks or thumbtacks, 214,656

n) Face care preparations, 4,309

o) Crayons or chalk, 2,054

Consumers can write to: The National Injury Information Clearinghouse, U.S. Consumer Product Safety Commission, Room 625, 5401 Westbard, Ave., Bethesda, Md. 20207.

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EL PASO TIMES

UNREASONABLE PANIC PARALYZES 1 OF 10 IN U.S.

Insidious, baffling and often bizarre, they are the most common mental health disorders in the United States - yet also among the most frequently overlooked and rarely treated.

Up to 24 million people in the United States - about one in every 10 are afflicted by phobias of varying severity at some point during their lives. They can be so disabling that their victims are virtually imprisoned, unable to carry on normal, everyday activities.

A phobia is not just a very intense fear, but rather an entirely different experience, said Dr. Manual Zane, director of the phobia clinic at The White Plains (N.Y.) Hospital Medical Center and co-author of "Your Phobia" (Warner).

Fear is a normal, appropriate response to some real or imagined danger. A phobia is a persistent, overwhelming and uncontrollable dread of an object or situation in the absence of any threat.

Phobic people are gripped by feelings of "total emotional disorganization, a sensation that they are going out of control, that they are at the edge of final, irrevocable disaster," Zane said.

Sometimes phobias develop after a series of sudden "panic attacks." They become bouts of intense anxiety that strike with a barrage of frightful physical sensations: rapid, shallow breathing; palpitations; trembling; sweating; dizziness; nausea; and weakness or tingling in the limbs.

Panic attacks may be provoked by a specific phobia or they may occur spontaneously, for no apparent reason. The symptoms are so unnerving that budding phobics soon learn to fear their recurrence. They imagine themselves going beserk, fainting, screaming hysterically or even dying when confronted with whatever terrorizes them.

If their original outburst occurred in a shopping mall or while crossing a bridge, for example, panic-stricken people are likely to shun these and similar settings the next time to avoid experiencing the same physical reactions and tormenting thoughts.

Ultimately, the areas or things that they consider off limits may be spread by association until their range of activities becomes extremely restricted.

According to The American Psychiatric Association, phobias fall into three main categories; simple, social and agoraphobia.

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At its name suggests, the first kind is usually aimed at something fairly concrete, such as cats, insects, thunderstorms, elevators or flying.

Social phobias involve a dread of being watched and evaluated by other people and inviting their ridicule or disapproval. Thus, "public" activities, including reading aloud, making a speech, attending parties, eating out or performing even trivial tasks in front of strangers create extreme anxiety.

Agoraphobia, the most pervasive and crippling of all, is a feeling of panic and entrapment in places away from home or any area perceived as "safe." While it is usually referred to as a dread of open spaces, it can erupt almost anywhere.

Help includes short-term group and individual psychotherapy, behavior modification, relaxation exercises, and special drug therapy to treat the disquieting symptoms.

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LOS ANGELES TIMES

ASPIRIN HAS A WINNING TRACK RECORD

Once again, aspirin has come out of the medicine cabinet and into the limelight.

The recent spread of publicity apparently confirming its role in warding off heart attacks is, more than anything, testimony to the remarkable staying power of a drug first patented by Bayer in 1899, a year after the German pharmaceutical house introduced a promising new cough medicine called heroin.

Since then, aspirin - originally an extract from willow bark has risen and fallen from therapeutic grace, and suffered and repelled challenges by newer pain relievers. Through it all, sensational claims have mixed with public confusion over its benefits and side effects.

The latest round of fascination with the drug, first introduced as a fever-figher, was set off by news of a still incomplete national study of more than 22,000 U.S. doctors who found that taking a 325-milligram tablet of the aspirin product Bufferin reduced the odds of having a heart attack.

Stores quickly reported increased sales, and aspirin makers lobbied retailers to add to their inventories. All but obscured in the commotion was the fact that a Glendale, Calif., doctor had pioneered much the same theory in the early 1950s.

Now as then, the public was quick to pick up on the good news while ignoring the downside.

"I think the public is looking for easy ways out," Dr. James Schoenberger, a prominent Chicago prevention expert, said of the recent report. "They want the magic pill, the magic bullet to prevent them from ever getting a heart attack."

But Schoenberger, like other experts, was quick to add: "If you're going to do something like start taking aspirin when you're 40, for the next 25 years, to prevent a heart attack, long-term effects of aspirin might be very important to you."

VENERABLE MEDICATION

Just what are the pluses and minuses of this wonder drug?

Aspirin's staying power over the year has been primarily as a result of its versatility and low cost. Alex Savanian, an associate professor at the University of Southern California School of Pharmacy, said aspirin - now technically called acetylsalicylic acid - still offers such unique medicinal properties that is is likely to remain an important part of the pharmaceutical arsenal for at least the next 20 years.

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The saga of aspirin's transformation from pedestrian tenant of the medicine chest to perceived wonder drug counts among the stars of its cast the Glendale doctor who in 1956 published the first medical journal study concluding that two aspirins a day could prevent heart seizures and strokes.

Sensationalized at the time, the theory, proposed by Dr. Lawrence Craven, was for a time the talk of the medical community.

Craven himself said he popped two pills every day in the belief it strengthened his heart. He said there had been no heart attacks among 1,465 patients to whom he recommended aspirin prevention therapy.

In language strikingly similar to headlines that greeted the release of the new study touting aspirin as a heart attack preventive, a tabloid in 1957 described Craven's work as "The one-pill-a-day defense against heart attacks." Aspirin, readers were told 31 years ago, was the "'old' wonder-drug with a new job."

Craven died a month later of a heart attack at age 74. But Craven it now appears, had been right, although the chemical explanation of why was not developed until after his death.

NEW INFORMATION

In the late 1950s and early 1960s, scientists came to understand prostaglandins, the naturally occurring fatty chemical rally occuring in fatty chemicals in the body on which aspirin works.

Prostaglandins are found in various body organs, including the prostate, brain, kidneys, lungs, pancreas and even seminal fluid. While many of the interactions of aspirin and the prostaglandins are still somewhat mysterious, enough is now known to permit scientific interpretation of the effects of the drug and its natural chemical predecessors that had been known to occur for centuries.

"Willow bark as a fever treatment, for instance, had first been described scientifically by an English physician in about 1750 and the active ingredient, salicin, was isolated in 1829.

"Essentially, aspirin inhibits the production of these prostaglandins," said Dr. Earl Lockhard, medical director for Glenbrook Laboratories, the subsidiary of Sterling Drug that produces Bayer Aspirin in the United States.

In pain control, Lockhart said, "Aspirin appears to prevent formation of a type of prostaglandin that attacks pain-triggering tissue at a wound."

As a pain-killer, aspirin is called a "peripheral analgesic" because its pain-relief effect occurs at the site of the injury, not at more central "receptor" sites on which more powerful analgesics, like morphine, act.

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Aspirin's performance in fever relief, Lockhart said, is far more theoretical.

Prostaglandins exist in the central nervous system at the center of the brain, he said, near the location of the fever control center.

Animal studies have established that aspirin prevents formation of the prostaglandins near the fever control center. It is theorized that this may explain the fever-control effect in humans.

But is is aspirin's anti-clotting effect that is perhaps its most significant and complex action.

Loose in the bloodstream, USC,s Savanian said, aspirin binds itself to platelets to initiate the process recognized as clotting. Acting almost like a Teflon coating on the platelets, comes in contact permanently incapable of clotting.

Because myocardial infarctions and strokes occur when a clot breaks loose and damages the muscle tissue of the heart, in the case of heart attack, or the brain, in the case of a stroke, the clotting inhibition has the effect of being protective.

But because the anti-clotting action is indiscriminate and pervades the entire bloodstream, aspirin's greatest benefit is also its greatest potential danger.

It can dangerously thwart the clotting action of a wound. In combination with a natural tendency to irritate the stomach, aspirin can cause potentially catastrophic reactions in ulcer patients.

"I feel that it is going to be some time before we come up with a drug as widespread and effective as aspirin," Savanian said.

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LOS ANGELES TIMES

MORTALITY RATES AND NUCLEAR POWER PLANTS

CANCER INSTITUTE STUDIES 100 COMMUNITIES

Federal health officials, troubled by newly reported links between cancer and nuclear plant emissions, have begun an unprecedented national study of mortality rates in communities surrounding the nation's more than 100 power plans, officials said Friday.

Many questions - largely unanswered - have arisen periodically over the possible link between cancer and nuclear plants since the 1960s, but the new research effort was ordered in response to particularly disturbing studies conducted recently in Massachusetts and Britain.

Those studies suggest an incidence of leukemia near nuclear plants that, in some cases, was twice the normal expectation. The reports "alerted us to the possible problem, and we thought it was worth checking," said Dr. John Boice, chief of radiation epidemeology at the National Cancer Institute. "Our level of concern was raised."

The study of the nuclear plant emissions, which began in December and is to last 18 months, first was disclosed publicly this week by Sen. Edward Kennedy, D-Mass. It will compile cancer-related death rates since the 1950s in communities around the nation's nuclear power plants and compare them with other communities that are considered similar in composition and geography but are not exposed to the low-level nuclear emissions from nearby plants.

Public-interest groups and others involved with the issue at local levels, citing the potential to verify or disprove the evasive health connection once and for all, generally praised the federal government's impetus in undertaking the unique national study.

But an official with a national lobbying group that represents the nuclear industry contended that the study, by its very existence, lends credence to an unproven link between low-level radioactive emissions and cancer. In addition, it unjustly singles out nuclear plants as a possible source, said Ellen Werther of the U.S. Council for Energy Awareness.

"It's unfair to the American public to needlessly frighten them again," Werther said.

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EL PASO TIMES
March 26, 1988

EL PASO LEADS TEXAS IN NEW JOBS

2.8% overall gain outpaces other cities, but unemployment is still high

El Paso, which had one of Texas's highest unemployment rates in 1987, created jobs at a faster clip than any other large Texas city.

The Sun City particularly shone at creating manufacturing jobs, and wound up in 1987 with 2,500 more of those jobs, a 7.1 percent increase. In all sectors, El Paso added 5,700 new jobs, a 2.8 percent increase in the county work force.

Charles Page III, Executive Director of the El Paso Industrial Development Corp., said those numbers do not include companies like Hoover and American Izaki, both of which announced plans last year to build plants in El Paso. Those plants will open this year.

The Industrial Development Corp. is reponsible for luring new manufacturing jobs to El Paso. But many of the new jobs came from the city's apparel industry, which has been in El Paso for a long time.

Hector Venegas, labor market analyst for the Texas Employment Commission's El Paso office, said 4,100 jobs were added in the city's apparel industry in 1987. Even so, he said, the city is doing well creating jobs.

"We're exploding," Venegas said. "I've never seen anything like this."

But Page and Venegas, although expecting the growth in jobs to continue, don't expect the county's unemployment rate more than 10 percent for most of 1987 - to come down. Both agree that the rapidly growing city is adding workers faster than it's adding jobs.

New manufacturing jobs create more jobs in other areas, Page said. After a manufacturer hires workers, those workers create jobs in stores. Then, more service workers are needed. And, if the manufacturing employees buy houses, that creates construction and real estate jobs.

"If we do the manufacturing, everything else will follow," Page said.

Other border cities show the same kinds of increases. A study by the state comptroller's office shows that the border which has a chronically high unemployment rate was the only part of Texas that added jobs. And, the report said, next year the border should add jobs faster than it gains workers.

The Industrial Development Corp. study showed that El Paso outstripped the border overall in adding jobs. While the border added 1.1 percent more jobs in 1987 and the rest of Texas lost 1.2 percent of its jobs - El Paso more than doubled that figure.

"We are a bright spot, in spite of our unemployment," Venegas said.

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EL PASO TIMES
February, 1988

AIDS ABROAD

Rules for fighting epidemic differ from those in U.S.

The AIDS epidemic in sections of Latin America differs from the spread of the disease in the United States and may require educational programs tailored to different cultures, researchers say.

One such educational campaign is the intensive effort begun early last year by the government of the Dominican Republic, researchers said Thursday during a workshop on acquried immune deficiency syndrome abroad at the annual meeting of the American Association for the Advancement of Science.

In its first year, the campaign in the Dominican Republic had doubled condom use and dramatically improved public knowledge of the disease, said Edward Green, an anthropologist with John Short and Associates of Columbia, Md.

In Brazil, 70 percent of the 2,237 reported cases of AIDS occurred in the urban states of Rio de Janeiro and Sao Paulo, said Richard Parker, an anthropologist at the University of California at Berkeley.

Although many of those cases occur in homosexuals, homosexuality is thought of very differently in Brazil than it is in the United States, and thus education campaigns aimed at homosexuals are unlikely to be effective there, Parker said.

Most Brazilians think of themselves not as homosexuals or as heterosexuals but as either active or passive sex partners, regarless of their sexual preference, he told the conference.

He said that with no well-defined gay community, there are no gay institutions to help the government with its AIDS education efforts.

The symptoms of AIDS in the Dominican Republic are much different from those in Haiti, with which it shares the same island, said Linda Valleroy, an anthropologist working with the U.S. Agency for International Development.

Of the 399 cases of AIDS reported in the Dominican Republic, many seem characterized by diarrhea and gradual wasting away, she said. In Haiti, which has a much more severe AIDS problem, the disease often leades to Kaposi's Sarcome, an otherwise rare cancer.

In Mexico, AIDS has spread mostly among male homosexuals, as shown by the observation that there are 20 times as many cases among men as there are among women, Valleroy said.

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During the past three months, however, AIDS has begun spreading rapidly to women, she said. The ratio of male cases to female had dropped to 16 to 1.

"Mexico seems to be moving toward a more heterosexual transmission pattern, just in the last three months," Valleroy said. Mexico has reports of 1,049 cases of AIDS, she said.

The AIDS information campaign there has involved the release of a half million leaflets, stickers and posters, widespread television education, the distribution of condoms, and the cooperation of the Roman Catholic Church, she said.

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SUGGESTED ACTIVITIES FOR DEVELOPING COMPREHENSION USING JOURNAL ARTICLES

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SUGGESTIONS FOR DEVELOPING COMPREHENSION USING JOURNAL ARTICLES

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These suggestions will center around two major areas. The first is the skill of asking questions appropriate to the skill to be taught. The second will be specific suggestions for practicing the skills of comprehension.

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Questions for skill development. A prerequisite to the effective understanding of comprehension skills is the ability to ask questions which require the use of each specific skill as it is being taught and practiced. Suggested questions are listed below for each major comprehension skill.

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1. Purpose questions to keep in mind while reading
   a. Would you have made the same decision as ---?
   b. Can you find out if ---?
   c. What is the main idea of the author?
   d. What is the viewpoint of the author?
   e. What are the steps of the process?

2. Asking for the main idea
   a. What is the topic sentence (main idea) of the paragraph?
   b. What is the main point(s) of the author?
   c. What would be a good headline for the paragraph?
   d. What would be a good title for the article or story?

3. Noting details
   a. What facts did the author give?
   b. What time does ---?
   c. How much liquid ---?
   d. Where did the event happen?
   e. When did the emergency occur?

4. Seeing the organization of ideas
   a. In what ways are the two alike? Different ---?
   b. List the arguments for ---?
   c. List the various methods of emergency childbirth.

5. Understanding sequence (following directions)
   a. What steps do we follow when ---?
   b. What happened first ---?
   c. What do we do after ---?

6. Prediction and anticipation
   a. What do you think will happen next?
   b. Since he lost the patient, what will he do?
   c. What do you think will be the result of ---?

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SUGGESTED ACTIVITIES FOR THE SKILLS OF COMPREHENSION

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1 & 2. Recognizing the main idea

a. Express the main idea in your own words.
b. Underline the main ideas in several paragraphs in a textbook and note where they unusually are found.
c. Write a paragraph giving the main idea.
d. Give titles to paragraphs.
e. State an appropriate headline for a selection for a paragraph.
f. Check the main idea with the introductory and summary paragraphs of a chapter.
g. Select from a list of sentences the one that best expresses the main idea of a paragraph of a selection.

3. Noting details

a. Note relative importance of details by such signal words as above all, most important, of greatest value.
b. Notice the ways in which the author indicates the relative importance of details.

(1) By giving more space to one fact than to another,
(2) By the use of introductory remarks such as "above all" or "most important"
(3) By organization as indicated by headings in heavy black print,
(4) By the use of italics,
(5) By picture and other graphic aids, and
(6) By the list of important words at the end of a chapter.

c. Select a character or event that you like or dislike and and determine what the author had done to make you react to the character.
d. Match a series of details with a list of main ideas.
e. Study the regulations for operating a piece of equipment.
f. Answer detail questions included in a selection.

4. Organizing Ideas

a. Classify objectives according to their emergency care function.
b. Tell what items belong in classifications, such as poison and treatment.
c. Study the table of contents to note the organization of a book.
d. Catagorize information i.e., types of fractures or kinds of splints, treatment for different degrees of burns.

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SUGGESTED ACTIVITIES FOR THE SKILLS OF COMPREHENSION

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5. Seeing the sequence
    a. Read the main ideas in a chapter to get an overview of the sequence of the material covered.
    b. Enumerate the steps of a process or in a chain of events.
    c. Notice the words that suggest the introduction of another step, such as, the, finally, second, another, subsequently.
    d. Note the steps in proper order for constructing some object, doing some written assignment, doing an experiment.
    e. List the chain of events leading to some scientific discovery.

6. Predicting and anticipating
    a. In a situation of confusion and indecision, anticipate what you think will happen next. Why?
    b. Compare present-day conditions with those of a certain period in the past, decide what will happen next.
    c. Consider what will happen next in light of

        (1) Background events,
        (2) Character involved, and
        (3) The situation

    d. Make up endings for stories.
    e. Estimate the answer to an emergency situation.

The comprehension skills are basic to a reader's practical as well as pleasurable use of reading. These are the skills which give genuine purpose to the reading act.

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EMERGENCY
January, 1987

OPEN FORUM

LET'S SHOW SOME RESPECT, BUDDY

I have spent a little time in the "Big City" working EMS, and a lot of my colleagues at many levels believe that introducing oneself to the patient is, if not merely a waste of time, then a veritable magnet for trouble. Either they believe that EMS is "about emergencies, and so we just don't have the time to hold hands," or they feel "if they don't know who you are, you can't get sued/written up/complained about." I see a couple of weaknesses in these approaches to emergency medical services.

The investment of a minute or two in introducing yourself to the patient, and learning his or her name is not a waste of time, and is usually the beginning of the smooth progression of the scene, high quality patient care, and a satisfaction that is to be found in EMS as an avocation.

Emergency intervention begins with somebody letting a very scared human being know that there are people around who are not only going to try to remedy things, but who realize that the injury or illness is very frightening. Merely stating this is not likely to convince them that you are serious, if your care is mechanical or insensitive. Just as you cannot convince a new partner that you know your stuff simply by loudly proclaiming the fact, so too you must demonstrate that your care is gentle and comforting. The smooth, confident manner in which you carry out your duties speaks volumes to the patient - and that partner - about how well, indeed, "you know your stuff."

One of the best ways you can let the patient (and family) know that you do have things under control, is to act like you have the time to carry out your procedures well. This can be demonstrated by letting a patient know your name and, meanwhile, carrying on with your care. This is especially effective with kids; and the combination of an introduction, a supportive line of patter and calm, quiet care, results in a child who is more trusting, more cooperative and not screaming at every new development. Try to envision the amount of energy a child expends trying to escape with his or her life the "scary" strangers and their instruments of torture, and then imagine what that energy could have done to promote the healing of a severely injured child.

Communicating to a patient and the family is therapeutic because the root of physical healing is psychological. That psychological care may be a major part of the care that you can give. If you are running as a basic unit, your ability to render definitive care to a person experiencing, say, a major MI is rather limited. You would do well to remember that the major killer of MI patients is V-fib, which can occur when large amounts of endogenous catecholamines (read; epinephrine) are released in large quanitites in the bodies of folks who are very afraid. Therefore, if you can reduce the fear your patient feels, you may save his or her life.

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Introducing yourself and using your patient's name will not only reassure your patient that you aren't overwhelmed by his or her condition, but will also serve other, secondary goals. For example, something like "Howdy, my name's Seavor, I'm a paramedic. What's your name? How can I help you?" not only answers the musical question, "Just what the hell are you doing in my living room in the dead of night?" but also establishes your non-offensive intentions. You can also stop the use of offensive demeaning and unprofessional terms like "buddy," "partner," and "hey, you." Few mothers named their children such things in a recent exhaustive survey, and whatever else, your patients may be, they are somebody's children. If you speak to all your patients just like you would your own parents, you will head off a lot of potential for misunderstanding and confrontation.

On a more technical level, introducing yourself to the patient allows you to start assessing the patient while getting out your equipment. The person who strains to get the wind to speak his name is a candidate for more tightly focused assessment, and maybe for expeditious intervention, either pharmacological or transportational, according to your level of practice. The person who responds by attempting to explore your employer's duty injury policy with you as guest of honor, may be experiencing a metabolic derangement severe enough to warrant prompt transport. Finally, few dead folks, in my not particularly limited experience, speak in response to any sort of stimulation.

Such an approach not only gives you a second to get yourself together, but also lets the patient know that things are beginning to get back to normal. The use of daily courtesy tells the patient that you are noting and respecting his or her value as a human being, and are professional enough not to get unnerved by the chaos that is rampant at the scene of an emergency situation. You say, nonverbally, to your patient that the situation is not so out of control that you are regressing to juvenile, unsophisticated behavior. I once worked with a guy who was as sharp as could be in casual conversation, but on one shooting that we worked, he lost his cool altogether and began to shout at the family to get out of the room in which we were trying to work. It was not only rude, but it demonstrated that he felt the scene was out of control and beyond his capacity to cope. He let everybody know, accurately or not, that he couldn't handle it, and that cannot have a salutary effect on the patient.

The provision of psychological comfort is the beginning of physical healing, and may well be the only care that you can give. You can't do much for the recipient of a large-caliber gunshot wound to the head that will materially affect his clinical course. But, the fact that you are working hard on this person allows the family time to accept the situation, and ease into the grief that will be theirs. In short, you let them feel like they did everything they could for their loved one because, "look how hard the medics worked on Billy." This therapeutically promotes the family's transition into the states of productive grieving with minimal inappropriate guilt. And didn't we get into this business so that we could help other people, particularly in situations where everybody else is unable to do anything?

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Non-verbals are granted greater reliability than speech by observers. We tend to believe what we see, over what we hear, when the two contradict each other. Who will pay attention to the words of unknown weapon wielders, who assure that they mean no harm? The fact that they choose to bear arms is all the communication most of use need! Who will pay attention to the shouted declaration, "I AM NOT ANGRY!!!" So the way in which you say something has implications for the other messages you are conveying, even inadvertently. When you take the time for an introduction, you are communicating in the most convincing manner possible that you have things under control. This is of tremendous help to the patient and the family coping with what is, subjectively, a catastrophe. I have been told many times that "as soon as you started talking to me, I just knew that my (father/brother/mother) would be all right and that helped me a lot."

Finally, introductions pay off in more enjoyment of your job. People are more likely to write congratulatory letters to your employer when they know about whom they are writing. You humanize the job when you deal with people with names, instead of the "fractures" and "bellies" that you transport. You open the door to discover the fact that no matter how much your subject may resemble a dirtball, this person, too, has a mother who loves him, and has a story to tell... one that you might even find interesting, instructive or touching. And when you treat the patients that you encounter with respect, then you see the worth of your vocation. When you take pride in your job, you get respect for the job that you do. That pride is reflected in the way that you deal with the public. By introducing a humane element into the terror of the emergency scene, you avoid becoming alienated from the very reason that you entered this madhouse in the first place: to try to make one corner of the planet a little less hostile for one person at a time.

EMERGENCY
by Jon E. Dougherty, EMT-P
February, 1987

TRAUMA PRIMER

WHEN IN DOUBT....ASSESS

Many true skills in the world of EMS are often underestimated and are covered lightly or merely shrugged off as unimportant. Proper assessment can be one of the most frequent.

Did you ever transport a patient who seemed as though more should be wrong with him or her, or you were surprised to hear the final diagnosis after emergency department treatment? Do you remember how you felt? Do you think that you should have picked up on that particular illness or injury prior to ER arrival?

In an emergency situation, obtaining facts and clinical history about an individual can prove trying, at best. Nevertheless, this verbal gathering of information is our initial step in determining the problem. In the ideal situation, the patients themselves should be questioned first.

Verbal assessment, whether given by the patient, the family or knowledgeable bystanders, is important for reasons other than simply immediate history. For instance, if you respond to a patient who is suffering from chest pain, you will want to know if the patient (1) has a history of cardiac illness, (2) if this episode of chest pain is similar to the last one, (3) if it is not limited to the substernal area, does it radiate and if so to the same place as before, (4) does the patient take any medications for cardiac trouble, (5) does the patient have a pacemaker, (6) does the patient have a history of heart surgery, and so on.

After a verbal history is obtained, or while it is being obtained, a measurement of vital signs can help judge the extent of your patient's dilemma.

For ALS providers, the cardiac monitor is a very useful diagnostic tool for assessing what cannot be seen. Of course, treatment is never to be directed at what the monitor is showing, but, again, at what the patient is demonstrating, in conjunction with a monitor reading. A prolonged PR interval, a falling ST segment, widening QRS complex, or the occurrence of premature ventricular ectopic activity, all point to a potential problem the patient may experience. With this knowledge, the paramedic possibly can arrest a dangerous situation before it occurs.

There are a total of nine vital signs - blood pressure, pulse, respirations, skin color, skin temperature, pupilary reaction, ability to move, and so on. To fully make an assessment, all of the basic diagnostic signs must be examined as quickly as possible. Specifically, pulse and respirations can provide instant tip-offs to something that has happened within a patient.

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Whether medically or traumatically oriented, certain tip-offs usually become immediately visible. Besides the more obvious condition of cardiac arrest, less subtle medical dispositions of acute anaphylaxis, diabetic coma and insulin shock, and severe respiratory distress, often are present with signs and/or symptoms that are quite easily seen. Some of these include cyanosis, which is a late sign of acute respiratory acidosis or diaphoresis that is profuse in nature, or perhaps even unconsciousness. Whatever the etiology, patients with a serious problem may not easily present themselves until early in the secondary survey, when vitals are taken.

Multisystems trauma, on the other hand, often demands that the EMS provider assess with much more haste or in a different manner. According to recent changes in trauma care designated by "Pre-Hospital Trauma Life Support" (PHTLS) guidelines, critical trauma patients indeed require a survey, but on a drastically reduced scale.

In addition to a survey of a conventional means, PHTLS advocates that a specific degree of the survey be speculative, when considering the mechanism of injury. This is done by a process called "kinematics" which basically means that EMS providers examine the situation, and suspect patient injury due to the amount of energy created by the accident, determining where the energy will travel in the body, and what extent of damage should be expected.

Without a doubt, airway assessment is the most important evaluation EMS personnel make-whether they are basic or advanced. Serious mistakes have been made in this area due to the tendency of personnel to assume an airway is patent as long at the patient is breathing. Assessment of how the patient is breathing in relation to rate and depth is vital.

Procurement of an adequate airway is next on the agenda. Depending primarily on level of training, the most uniform acceptance of intervention is endotracheal intubation, if indicated. With this method, patient airway management is feasible, and often improves a patient's overall condition.

Once the airway has been maintained, the assessment of bleeding and circulation must follow. Many times this technique can be performed with a quick visual scan of the patient, and appropriate treatment can follow. In respect to the circulatory system, factors that present when you first arrive can indicate which way the patient is heading.

If, however, your patient presents in a better manner, and can tolerate (both clinically and emotionally) a thorough exam before transport, then the assessment should be made at that time. Being too careful has rarely been a vice associated with EMS personnel. Just the opposite has been the norm, which is why we are taught to thoroughly assess in the first place. As only about 8 percent of the patients encountered will be in dire trouble when you arrive at the scene,, the other 92 percent demand adequate treatment and proper understanding of what is wrong with them. Remember that you're not finished until you reach the hospital. Many patients require continuous monitoring of their illness throughout transport, and retaking vitals and rechecking body systems is all a part of the original contact. Responsibility for the ill and injured doesn't end until delivery is made to the ED or, in some areas, until more advanced care arrives and assumes the responsibility.

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MAYO CLINIC HEALTH LETTER
September , 1987

DROWNING PREVENTION

These Water Safety tips Could Save your Life

A five-year old boy was pulled out of water after being submerged for 40 minutes. Given first aid at the site and rushed to a hospital, he recovered completely. A 21-year-old man was rescued after a five-minute submersion. On the way to the hospital, he began to breathe spontaneously - but the next day he was dead.

As these case summaries show, your chances of survival in a water emergency can vary widely. Experts have new understanding of the way drowning happens and how to treat it. But swimmers themselves - and bystanders - play a crucial role. Many drownings can be prevented.

WHO DROWNS - AND WHY?

Each year, 80,000 Americans are involved in a water emergency. Nearly 8,000 of them drown. And recently, physicians have become aware of a related problem - "secondary drowning" or "near drowning" - in which victims die of lung congestion and pneumonia, even though they are rescued from the water and initially appear to be recovering. In statistical surveys these deaths often are not reported as drownings, but there may be several thousand such fatalities each year.

Drowning is the third most common form of death in children. Forty percent of all victims are younger than four years of age. Boys are three times more likely than girls to drown.

You must be careful at all times in the water. This is especially true for children, the elderly and persons with epilepsy or physical or mental handicaps. Drowning deaths in adolescents and adults often are associated with the use of alcohol or other drugs that affect the brain.

Drowning is a form of suffocation ("asphyxia"). Typically, it begins with panic and a struggle.

Attempts to hold breath are unsuccessful: the victim exhales air, then inhales water into the breathing passages. Loss of consciousness, seizures, cardiac arrest and death may follow. In about 85 percent of fatalities, the lungs contain fluid; in other cases, persistent spasm of the vocal cords causes suffocation, and little or no fluid enters the lungs.

FACTORS ASSOCIATED WITH SURVIVAL OR DEATH BY DROWNING

a) Hypoxia - Reduction of oxygen supply damages body tissues, especially the brain.

b) Pneumonia - Aspiration of bacteria, chemicals or debris into the breathing passages causes inflammation of the lungs.

c) Hypothermia - Hypothermia, a reduction in normal body temperature, can be harmful by causing rhythm abnormalities in the heart, reduced blood circulation and unconsciousness. It also can help prevent death. After submersion of the body in cold water, the reduced temperature helps prevent brain damage by reducing oxygen needs. Children may experience a "diving reflex," which shunts oxygen-carrying blood from nonessential organs to the heart and brain.

PROMPT ACTION AT THE SITE IS VITAL

In one study, 75 percent of drownings took place in front of people who did not know how to help. Whether a drowning victim suffers permanent disability or even survives depends largely on the immediate response of people nearby:

a) An estimated 90 percent of drownings take place 10 yards or less from safety. In many cases, you can extend a pole or float a buoyant device. Only strong swimmers should attempt to swim out to the victim.

b) Learn CPR (cardiopulmonary resuscitation). Mouth-to-mouth ventilation dates at least to Biblical times (II Kings 4:34-35), and CPR instruction has been available to the public since the 1960s. It's saved many lives.

c) Call an ambulance. Every person who has been rescued from the water should to to a hospital to limit the danger of death due to "secondary drowning."

As more people learn lifesaving techniques, and with advancing technology in ambulances and hospital intensive respiratory care units, we can expect that even more individuals can be saved from drowning.

MAYO CLINIC HEALTH LETTER
July, 1987

HOME SAFETY

Smoke alarms and sprinklers offer affordable protection from fire hazards

From 1965 to 1985, Canada had the largest number of fires and fire-related deaths of any country in the industrial world. The United States ranked a close second.

From 1977 to 1983, almost 7,000 Americans died annually in home fires. That's equivalent to the crash of two large jet airplanes each month. People at greatest risk: children younger than age ten, the handicapped and adults past age 65.

A MAJOR CAUSE OF DEATH

Fire is the third-leading cause of accidental death and injury in the United States. Each year, it causes 20 times more deaths than hurricanes, tornadoes, floods and earthquakes combined.

Home fires make up only 25 percent of all fire, but they account for 76 percent of fire-related deaths. Fatalities more often are due to inhalation of carbon monoxide and other gases in the smoke than to heat and flame. Careless smoking leads to the greatest number of deaths. Cooking is responsible for most injuries. Arson creates the bulk of property damage.

We strongly discourage smoking, but if you do smoke, remember that it's especially dangerous to smoke in bed. Your risk of death from a home fire increases if you smoke when you are tired or if you have been drinking. A practical approach to home safety is vital.

For added security, equip your home with smoke detectors or a sprinkler system or both. Improved technology and competitive pricing make these devices more accessible today.

THREE TYPES OF DETECTORS

The U.S. Department of Health and Human Services states that detectors are of special help in fires caused by careless smoking, or if you're asleep when the fire starts. The first detectors for home use were introduced in 1921, but their cost was prohibitive. Since 1970, battery-operated alarms have brought down the price. Today's models cost from $10 to $50.

Three types of detectors offer home protection. One sounds an alarm in response to heat (a specific temperature or a rate of increase in temperature). The other two respond to smoke or various particles in the air.

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The Journal of the American Medical Association reports a safety comparison of homes with and without detectors. In a house fire, your chance of death is 2.5 times greater if the home does not have detectors. In an unprotected mobile home, your chance of death is two to four times higher.

SPRINKLERS: NOW MORE AFFORDABLE

Although detectors sound an early warning, handicapped persons, the elderly and the young may not be able to escape. For them, a sprinkler system can help.

Commercial sprinklers have been available for more than a century; the first models for residential use came on the market in 1978.

Here is how they work: normally, a metal link keeps the sprinkler's water valve closed.

The heat of a fire softens the link, thus releasing the valve and a spray of water. Hot gases and carbon monoxide levels tend to rise fast in homes. Therefore, look for a home sprinkler system that reacts quickly; some respond within half a minute.

Installation of a sprinkler system typically costs about 2 percent of a new home's value and 3 to 4 percent of the cost of an existing structure. When local codes permit, piping made from synthetic materials reduces expense.

In the event of fire, sprinklers can cause water damage, but it is less severe than destruction from smoke and flame. The risk of water damage from leaks is extremely low.

A RECOMMENDATION

The National Fire Protection Association and many other organizations advocate installation of alarms in all new residential and commerical buildings. We agree. Tax incentives and insurance adjustments could make this plan attractive to more people.

Smoke detectors alone could reduce home fire deaths by about 50 percent. Detectors and sprinklers combined could save up to 73 percent of the people who die each year in fires.

If you get a detector or sprinkler system, carefully follow all instructions for installation. Inspect the equipment regularly. Plan and rehearse an escape route from your home. If you're caught in a fire, these simple precautions might save your life.

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MAYO CLINIC HEALTH LETTER
August, 1987

SMOKING CESSATION
Here's how to do it

STOP SMOKING TODAY

You've heard that message in more than 20 Health Letter articles published over the past several years.

We've covered the many hazzards of smoking. Now we'll highlight specific ways you can quit, based on Mayo's experience in helping all types of smokers make this positive change in their lives.

Fair warning: smoking is more than a habit. It's an addiction involving chemicals that affect your behavior. Quitting is difficult. People fail, but there is no reason to give up. Making a commitment to stop, and then living up to it, can be one of your most rewarding accomplishments.

Here's how you can do it:
a) Set a date - pick a date to quit. Make it reasonably soon. Then list on paper the reasons you want to stop. Before you begin your attempt and frequently thereafter, review the points on your list.

b) Before you reach your stop date, make changes in your normal routine that are mildly disruptive. Switch to a brand less appealing. Use matches instead of a lighter; or vice versa. Reduce your nicotine dose by changing to a milder brand. Then taper off - begin a gradual reduction in the number of times you smoke each day.

c) Make your plans known. Go public with your commitment to stop smoking. Tell your family, friends and colleagues. Give them specifics: when and why you are going to stop. Ask for their support.

d) Take it one day at at time. On your stop date, quit completely. From that point on, take it one day at a time. Decide not to smoke for that day alone. Focus all of your attention on achieving that goal. Don't worry about tomorrow until it arrives.

e) Change your routine. Avoid or change situations in which you previously smoked. Drink your morning coffee in a different location. After meals that ended with a cigarette, leave the table promptly; take a walk instead of lighting up. If you smoked while using the telephone, avoid prolonged conversations or change the location of the phone you use. If you have a chair you favor for smoking avoid it temporarily.

f) Alter your surroundings. Before the urge to smoke strikes, start activities that make smoking physically difficult to perform. Physical exercise of all kinds can help. Take a shower. Wash the car. Pull weeds in the garden.

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g) Time the urge. Check your watch whenever an urge hits. Most are short-lived. Once this is apparent, you will be better able to resist the urge.

h) Prepare a daydream. Have a pleasant daydream available to ward off the urge to smoke. Call on it as often as necessary.

i) Use relaxation techniques. Breathe deeply and slowly as though you are inhaling a cigarette. Repeat this procedure several times.

j) Practice positive thinking. Reverse the negative "I can't do it" type of thinking. Take a positive approach. "I can make it another few minutes and the the urge will pass and I will be okay."

EXPECT A CHALLENGE

Once you quit smoking, physical withdrawal symptoms will persist for one or two weeks. The urge to smoke may last longer, but this also decreases in intensity with time.

Most relapses occur the first week after a person stops. The reason: withdrawal from nicotine is incomplete. Relapses during the first three months most often are caused by the lack of new, nonsmoking habits. A change in your routine is vital.

Remember this: most former smokers cannot smoke "just one." And if you light one, you don't have to smoke it. If you start if, you don't have to finish it. And if you do, you are not a failure. This is nothing more than a temporary setback.

Your habits related to smoking may be so ingrained that they are automatic. Anticipate this automatic behavior and plan alternatives. If you kept cigaretts in your pocket, wear a shirt without pockets.

YOU REALLY CAN STOP

It may be difficult to stop smoking - but not impossible. Each year, three million Americans are successful. Many of them failed on previous attempts. If you failed in past efforts to stop smoking, don't be discouraged. Instead, learn from your experiences and set another stop date.

Your physician can be helpful, or you can seek out a smoking cessation program in your community. Nicotine gum, when used as an adjunct to a treatment program, also can help. A wide range of self-help material is available from agencies such as the American Lung Association, American Cancer Society and American Heart Association.

Most successful ex-smokers experience failures before they succeed. Only a few are able to quit on their first try.

Persistence usually pays off.

Remember, there is life after smoking - and there may be more of it.

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READER'S DIGEST
by Peggy Mann

THE HIDDEN SCOURGE OF DRUGS IN THE WORKPLACE

The productivity of American workers has hit new lows, at least in part because so many of them are hitting new "highs" - on drugs

In April of 1982, 39 recruits nearly a quarter of the graduating class of the Washington D.C., Police Academy were suspended after urine tests showed they had been smoking marijuana. Says Police Chief Maurice Turner, "How can we expect a policeman who is abusing the law in our biggest problem area to enforce that same law?"

a) In September of 1981 an iron worker fell five stories from a highrise under construction near downtown Houston. An autopsy showed he had barbiturates in his blood, as well as more then enough alcohol to be legally intoxicated.

b) In California's "Silicon Valley," drug use at one electronics firm is such a shoulder-shrugging affair that employees openly dry their cocaine in a company microwave oven.

Twenty years ago 96 percent of Americans had never used any illegal drug, and drug use on the job was almost unheard of. Today there is barely a work category that does not have its quotient of drug users. Says Dr. Joseph Pursch, medical director of Comp Care Corp., the nation's largest provider of alcoholism and drug treatment programs. "Drugs in the work place constitute the number one public health problem in this society today."

A decade ago almost all of Comp Care's patients were alcoholics. While the alcohol problem is still of great concern, increasing drug use is inflicting its own widespread devastation. Explains Peter Bensinger, former head of the U.S. Drug Enforcement Administration and now president of Bensinger, DuPont and Associates, which deals with drug abuse policy for private industry, "The alcohol abuser generally will not show up on the job drunk. He'll be late or will call in sick, for fear of losing his job. Supervisors can spot alcohol intoxication - the breath smell, the attitude, the gait. However, most supervisors are not familiar with the look and behavior of illicit drug users. Therefore, the drug user is far more likely to go to work while under the influence of drugs, and to use them on the job. It's a lot easier to hide a few joints or pills than a bottle of bourbon or a six-pack.

Virtually all taxi and limousine companies have strict rules pertaining to alcohol, but few say anything about the impairing effects of marijuana on driving. This comment from a New York City cab driver, who also has worked in Los Angeles, is typical: "I know about one hundred drivers, and a good thirty percent smoke dope. They smoke in the garage while waiting for their cabs to come in. And when there is lull during the evening, they'll pull over in a secluded spot and light up a joint."

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Some truck drivers are under the misapprehension that marijuana actually helps their driving. This is of special concern, since not only are truckers on the road for longer stretches of time than are other drivers, but they pose a greater hazard with their mammoth vehicles.

Alcoholics almost invariably support their drinking with their paychecks. While chronic drug users often cannot do so. Cocaine, for instance, is far more expensive than its equivalent weight in gold dust. This encourages illicit activity on the job, such as employee theft. Estimates of losses incurred by drug-induced stealing and productivity losses are in the billions of dollars yearly. Drug use also results in employee morale problems, absenteeism, injuries to both users and non-users, higher insurance rates and increased turnover.

How many people are involved? After surveying 20 large corporations, Lee Croft, director of Croft Consultants, a drug education and counseling firm in Phoenix, concluded that at least four million workers in the United States are abusing drugs to the extent that they have been referred for treatment. According to both government and private-industry figures for the period 1978 to 1982, the loss in productivity of these workers cost firms an average of \$4250 per worker, per year. These costs an annual \$17 billion are added to the price tag we all pay for goods and services. Croft calls this out "Toxicomania Tax" the extra \$74 every man, woman and child in America pays because of drug use by workers. "If we could get rid of drugs in the workplace," says Ira Lipman, head of the Memphis-based security firm Guardsmark, Inc., "We'd be ahead of our countries in productivity, not falling behind.

Even drugs taken by employees off the job can have effects in the workplace. Marijuana, for example, can impair abilities for up to four hours after the person finished smoking it. In February 1983, the U.S. Court of Appeals ruled that the Federal Aviation Administration (FAA) was justified in firing an air-traffic controller for off-duty possession of marijuana. The court held that any involvement with illegal drugs was incompatible with this occupation.

So far, the ruling has meant little. According to a May 27, 1983, article in The Wall Street Journal: "There is disturbing evidence that many air-traffic controllers have been users of mind-altering drugs, including marijuana, hashish and cocaine, and that many still are though FAA officials and controllers alike have tried to keep the problem quiet. More than once, by some accounts, there have been near-tragedies. Thus far, though, no effective crackdown appears to have taken hold.

Despite the hazards of drugs in the workplace, little is being done about the problem. According to a 1982 U.S. Public Health Service report: "Eighty-five percent of people with a substance-abuse problem aren't getting any help." A mere 12 percent of all firms provide employee-assistance programs for drug and alcohol abusers.

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Many employees who are taking action use undercover agents, and the positive results are often quick to come. For example, when rising operating costs and late shipments pushed a division of Armco's National Supply Co. into the red, a six-month undercover investigation led to the firing of some 25 employees for drug violations. One week after the firings, minor accidents had decreased by two-thirds, productivity was up 15 percent. Within three months employee turnover, which had been running about 30 percent, declined substantially, and the plant was back in the black.

But undercover investigations are obviously only a partial answer. Says Peter Bensinger, "The best approach to this nationwide crises is to use drug user's dependence on their jobs to start the rehabilitative process and to use job leverage to keep the employee in treatment until he or she is cured. The threat of being fired if the employee does not agree to seek help and to remain in treatment is the single greatest rehabilitative tool we have."

To accomplish this, supervisors must be trained to spot drug abusers. Although not so great as in the case of alcohol abuse, absenteeism is one prime clue. Others include more frequent trips to the washroom, falling asleep, carelessness and abrupt mood changes. Once identified, the employee should be made aware of company policies regarding treatment and should understand that failure to take advantage of help could result in dismissal.

Increasingly, companies and unions are joining together to provide outside treatment programs. Often the drug user is given a leave of absence with a promise of reinstatement when he or she is drug free. And more and more companies are adding drug treatment coverage to their health insurance policies.

Are rehabilitative programs cost effective? A study conducted for General Motors by research consultants at the University of Michigan found that during the first year after entry into a program, employees had 40 to 60 percent reductions in absenteeism, sickness and accident benefits utilization, and occupational injuries. The researchers figured that for every dollar GM spent on such treatment, the company would save more than two dollars within three years.

It would seem, therefore, that we have answers to this major national problem. What we need now is the determination to put them into action. Dr. Carlton Turner, special assistant to the President for drug abuse policy, summed up the situation with this sobering thought: "If our country does not wake up and address the disastrous and wideranging effects of drug abuse in the workplace, the United States is doomed to become a second-rate power."

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MAYO CLINIC HEALTH LETTER
October, 1987

HYPERTENSION

IF YOU HAVE IT, MAKE SURE YOUR BLOOD PRESSURE IS UNDER PROPER CONTROL

Sixty million American adults have high blood pressure. If you are one of them, this article is required reading.

Today, more than ever, Americans understand hypertension. They understand its causes. They can better manage it. They are familiar with the consequences of inaction.

SURVEY RESULTS

In a 1974 survey of people with high blood pressure, 51 percent knew of their problem; 36 percent were being treated for it. A follow-up survey ten years later showed that 85 percent of the people with hypertension knew about their condition and 74 percent were taking medication to control it.

The 1984 survey also found that people with high blood pressure are willing, for the most part, to change their lifestyles to improve their health: they exercise, cut down on dietary salt and lose excess weight.

This encouraging 1984 survey also revealed that nine out of ten American adults understand that high blood pressure increases the risk of heart disease; three out of four of those surveyed correctly identified high blood pressure increases the risk of heart disease; three out of four of those surveyed correctly identified high blood pressure as a major risk factor for stroke. Appropriate treatment lowers blood pressure and thus reduces disability and death from heart disease and stroke.

These advances in public understanding didn't happen by chance. The National Institute of Health, the American Heart Association and many other groups have worked hard to lower blood pressure by increasing public knowledge of hypertension. Their efforts are paying off.

That's the good news.

The bad news is that people who believe their blood pressure is under control may be misguided. Today, physicians believe that even mildly raised blood pressure carries health risks. Translation: your blood pressure should be no higher than 140/90, if at all possible.

OUR RECOMMENDATIONS

a) If you have hypertension, check your blood pressure regularly. Keep closely in touch with your physician for advice about what's best for you.

b) If you smoke, take more than two drinks of alcohol daily or are overweight, some changes are needed. Eliminate these factors and you may lower your blood pressure.

c) If, with medications, your blood pressure comes down to nearly normal, don't stop taking your medications. You may need to continue drug treatment indefinitely.

d) If you have side effects from your medicines, don't stop taking them. See your physician. Many alternatives are available. Your doctor probably can design a drug program that will meet your needs with no, or minimal, side effects.

MAYO CLINIC HEALTH LETTER
February, 1987

BLOOD TRANSFUSIONS

HOW SAFE? AND CAN THEY BE SAFER?

As heart surgery and organ transplantation become increasingly widespread, donor blood is needed more urgently than ever before. At the same time, some people now mistakenly hesitate to give or receive blood.

Fact: giving blood is a safe, humanitarian act. You cannot acquire a disease by giving blood.

Fact: receiving blood often is a vital part of medical treatment, but it does have risks. For example, transfused blood can transmit disease, even though the risks are very minimal.

To help solve this problem, an old technique is taking on new value. It involves transfusion of a patient's own blood. In addition to reducing the need for donor blood, the procedure enhances safety.

WHY USE YOUR OWN BLOOD?

Blood from your own body is the safest kind for transfusion. It minimizes your risk that disease may be transmitted via blood and blood products. Another advantage: you cannot suffer an immune or an allergic reaction from your own blood.

Use of your own blood is called autologous tranfusion (auto = self, logos = relation). It first was used in 1818, but only recently has modern technology given it widespread feasibility.

WHAT ARE THE OPTIONS?

There are two major types of autologous transfusion:

a) Preoperative (predeposit) - Your blood can be drawn and stored for a limited time. If you are scheduled for major elective surgery that required blood transfusion, this is an option worth considering.

Some people who, for various reasons, are ineligible to be blood bank donors still may donate for their own needs. They include patients older than age 70, persons with certain medical conditions and women in some stages of pregnancy.

b) Intraoperative - Blood lost during surgery can be collected, washed and returned to the patient. High-speed equipment can complete this cycle in three or four minutes. The technique is ideal for operations involving the heart and chest, but also may be useful for many other surgical procedures. It is not advised for most cancer surgery, where reinfusion of cancer cells is a potential danger.

ARE BLOOD TRANSFUSIONS SAFE?

We want to emphasize our confidence in the national blood bank system. Many people fear the spread of acquired immune deficiency syndrome (AIDS) via blood transfusions, but as of April 1986, only 2 percent of AIDS cases were linked to transfusions. The use of new screening tests will make it even more difficult for AIDS to spread this way.

On the other hand, hepatitis is a less publicized but greater problem. In some regions, 7 to 10 percent of transfusion recipients develop this ailment. The reason: there are no foolproof screening tests for certain types of hepatitis. Nevertheless, many blood bank physicians believe America's blood supply is safer today than at any time in the past.

The American Medical Association, American Association of Blood Banks and Red Cross all strongly endorse use of autologous transfusion and so do we. If you face surgery that may require a blood transfusion, ask your doctor about this safe, effective procedure.

MAYO CLINIC HEALTH LETTER
August, 1986

SOMETIMES PREVENTION IS POSSIBLE
DO YOU KNOW THE RISK FACTORS FOR STROKE?

This year 3,000,000 Americans will suffer a stroke. About 25 percent of these people will die within the first month, and half the survivors will have a long-term disability. After heart disease and cancer, stroke is the third leading cause of death in the United States.

The incidence of death from strokes increases with advancing years, doubling each decade after age 35 for both men and women. By age 84, the yearly risk of developing a stroke reaches two out of 100 persons.

But there also is good news: stroke is on the decline in our country. A study at Mayo Clinic reports that the incidence of stroke has decreased by almost 50 percent since 1955. Nevertheless, the disorder remains a major public health problem.

Are you at risk for a stroke? And if you are, can you improve your chances of preventing one? The answer to the latter questions probably is "yes."

WHAT CAUSES A STROKE?

There are two major types of stroke: "ischemic" and "hemorrhagic." The term ischemia (is-kee'meah) refers to a loss of blood supply. A narrowed or blocked artery obstructs the supply of blood to the brain and leads to the death of vital nerve cells within the brain. Ischemic stroke is by far the most common form.

Hemorrhagic (hem-o-raj'ik) stroke is less common. This disorder kills brain nerve cells by a hemorrhage (bleeding) within the brain itself.

RISK FACTORS FOR STROKE

It is not always possible to predict a stroke, but we do know many underlying conditions and warning signs. If any of the following risk factors apply to you, depend upon your personal physician for advice that is tailored to your needs.

a) High Blood Pressure - The best documented risk factor for stroke is high blood pressure. It also is the most treatable risk factor.

An estimated 70 percent of all strokes occur in persons with hypertension. There is a direct correlation: higher blood pressure means a greater risk of stroke. The marked reduction in stroke during the past three decades is largely due to drugs that effectively treat hypertension.

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In the past, doctors thought that diabetes, obesity, cigarette smoking and elevated blood cholesterol were independent risk factors for stroke. Although strongly linked to heart attacks, these conditions are much less linked to heart attacks, these conditions are much less significant than hypertension as risk factors for stroke.

b) Transient Ischemic Attack - Transcient ischemic attack (TIA) results from a temporary reduction in blood flow to a portion of the brain. Think of a TIA as a temporary, completely reversible stroke. It usually lasts less than 20 minutes, and recovery is always complete within 24 hours.

While TIA leaves no lasting damage, it can signal an impending completed stroke, from which there may be no recovery. (Among people who eventually have a completed stroke, about 10 percent have one or more TIAs in advance.)

Symptoms of a TIA depend on the site of the temporary artery block. Although symptoms may be numerous and varied, they generally resemble those of a stroke. But they are short-lived. TIA symptoms may include: numbness and tingling on one side of the body, loss of the use of an arm or leg, or vision difficulty. In the May 1984 issue of Mayo Clinic Health Letter, we discussed a condition called amaurosis fugax. This is a type of TIA that causes temporary loss of vision in one eye.

Sometimes, people with TIAs do not experience vision loss. But they still may have an eye problem. A cholesterol-containing plaque lodges in one of the small arteries that nourish the retina. The plaque is found only during examination of the back portion of the eye. We reviewed this type of eye examination (ophthalmoscopy) in the March 1985 issue.

c) Heart Disease - Heart disease definitely increases the chances for a stroke. If you have irregular heart beats, heart failure, narrowed coronary arteries or a deformed heart valve, you have more than twice the chance of suffering s stroke compared with people who have normal hearts.

d. Narrowing in carotid arteries - Narrowed sites in the carotid (neck) arteries, which supply blood to a large portion of the brain, sometimes are a forerunner of stroke. During a routine physical examination, your physician may place a stethoscope near the angle of your jaw over the carotid artery in your neck. This procedure might disclose a noise known as a bruit (brew'ee). The noise resembles certain heart murmurs. This finding sometimes indicates a significant narrowing of the carotid artery. But some specialists believe that most patients who have a bruit - and no other symptoms - will not develop a stroke related to blockage of that artery.

The likelihood of having a carotid artery bruit increases with age. In the Mayo study, the prevalence was less than 1 percent at 45 to 54 years and rose gradually each decade to reach 5 percent after age 75. Bruits were found in women two to three times more frequently than in men.

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If you have a carotid artery bruit or if symptoms suggest circulatory problems in your brain, several noninvasive tests can estimate blood flow through your carotid arteries. These outpatient studies have little or no risk.

If your doctor is considering surgical treatment, you probably will need a carotid artery angiogram. This x-ray examination requires injection of a contrast medium ("dye") into your circulation. It documents any sites of obstruction in the carotid arteries and their branches.

e) Alcohol Abuse - The evidence linking stroke with hypertension is strong. Although not as strong a link, alcohol abuse also may heighten the risk of stroke. Experiments with animals document an intense spasm, with narrowing of blood vessels in the brain, after animals are given large amounts of alcohol.

If these findings in animals also supply to humans, the studies may help explain clinical studies (with humans) suggestions that for 24 hours after binge drinking, the stroke hazard increases. If you drink alcohol, we recommend moderation for a host of health reasons, including the potential for stroke.

PREVENTION IS CRUCIAL

If you are at risk for a stroke, pay attention to these warning signs. Appropriate treatment or a change in your lifestyle could prevent or delay a stroke.

The most important potential change relates to hypertension. If you have high blood pressure, follow your physician's instructions to reduce it. Meticulous treatment with medications usually is effective. Other measures may include weight loss and a reduction in your salt consumption. Also, your doctor may suggest exercise, a special diet or stress reduction.

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MAYO CLINIC HEALTH LETTER
December, 1986

REYE'S SYNDROME REMINDER

IF YOUR CHILD OR TEENAGER IS ILL, READ THIS BEFORE OPENING THAT ASPIRIN BOTTLE

With the arrival of another flu season, a Reye's Syndrome reminder is timely. Reye's Syndrome is a rare but serious ailment in children and teenagers. It may strike just as the young person is recovering from an infectious illness, typically influenza or chickenpox. It can cause brain and liver damage and may lead to mental retardation or death.

Many physicians believe the use of aspirin is linked to Reye's Syndrome, but the relationship has yet to be convincingly documented. To be on the safe side, many American drug firms last year began voluntarily labeling their aspirin products with a warning advising parents to check with a physician before giving their children aspirin for flu or chickenpox.

Although manufacturers generally do not accept a casual relationship between aspirin and Reye's Syndrome, they are cooperating to the extent that in Great Britain, children's aspirin products have been voluntarily withdrawn from the market.

WARNING LABELS REQUIRED

Early this year, the Food and Drug Administration (FDA) issued a regulation requiring the following statement on all nonprescription aspirin medications and other products containing aspirin: "WARNING: children and teenagers should not use this medicine for chickenpox or flu symptoms before a doctor is consulted about Reye's Syndrome, a rare but serious illness."

In earlier years, evidence suggesting the aspirin/Reye's link was criticized as inadequate. More recently, the weight of medical opinion has swayed toward accepting the theory that a relationship exists. A major study is under way that may help settle the issue within the next two years.

GOOD REASONS FOR CAUTION

In the meantime, available evidence suggests there are good reasons for caution. In establishing the warning, the FDA took a conservative approach, one that we endorse. Our recommendations:

a) If your child or teenager has flu or chickenpox or any other fever causing illness, don't use aspirin to help relieve symptoms. If a medication is needed, select one of the readily available aspirin substitutes.

* * *

b) Be familiar with the symptoms of Reye's Syndrome: persistent vomiting, lethargy, confusion and irrational or belligerent behavior. These sometimes dramatic symptoms may follow symptoms generally associated with flu.

c) If you recognize any of these symptoms in your youngster, seek professional help immediately. Early hospitalization and treatment may save your child's life if he or she has Reye's Syndrome.

IS ASPIRIN SAFE?

Does the potential relationship between aspirin and Reye's Syndrome in children suggest that aspirin is unsafe for all people? Definitely not. When properly used, aspirin is a valuable, effective painkiller and anti-inflammatory drug that is used safely by millions of people worldwide. As with all drugs, aspirin should be used responsibly, after weighing risk and benefits.

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MAYO CLINIC HEALTH LETTER
August, 1987

ANAPHYLAXIS
This allergic reaction can threaten your life; it requires fast action

A bag of peanuts at the ball game. A bee sting on a camping trip. An injection of penicillin to clear up a troublesome infection. A shot of tetanus antitoxin in the hospital emergency room. What do they have in common? All four can cause an allergic reaction called anaphylaxis. It can be life-threatening.

Anaphylaxis results when powerful chemicals are released from highly specialized cells of the tissue and blood. Sometimes the cause is a true allergic reaction involving the same type of antibodies that cause hay fever and some kinds of asthma. At other times, chemicals are released without the involvement of any specific antibody.

MANY CAUSES

What triggers the reaction? Almost any food or drug may be responsible, although peanuts and penicillin are the most frequent causes. Wasp, hornet and bee stings are the most common insect sources.

Other causes include the intravenous injection of iodine-containing contrast material ("dyes") used during certain diagnostic x-ray exams. More rarely, anaphylaxis occurs during or after strenous physical exercise. In some people, the cause is never found.

Experts disagree on whether certain individuals are predisposed to the condition. Similarly, the problem seems to be more common among the older people, but has not been documented. Between episodes, most victims do not suffer lingering effects - but reexposure can cause additional reactions.

SYMPTOMS RANGE IN SEVERITY

Symptoms begin minutes after contact with the offending substance. Here is what to look for:

a) Worrisome symptoms - Skin flush, hives, localized swelling of lips or tongue, "tickle" in throat, wheezing abdominal cramps, diarrhea.

b) Life-threatening symptoms - Weakness and collapse due to low blood pressure, inability to breathe due to swelling of vocal cords, seizures.

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PROMPT TREATMENT IS ESSENTIAL

Initially, the most vital therapy is a prompt intramuscular injection of epinephrine (adrenalin). Often, it quickly relieves the symptoms. If you are subject to anaphylaxis, you should carry epinephrine with you at all times and know how to use it.

If epinephrine fails to work, see a physician promptly. Other drugs, such as antihistamines and cortisone-type hormones, may be necessary. For more serious cases, doctors may prescribe intravenous fluids. In rare cases, an emergency tracheotomy (trachea = windpipe, otomy = incision) must be done to open the airway.

ANAPHYLAXIS: THE STORY OF A NAME

The term "anaphylaxis" was coined early in this century by French scientists during research on protection from a toxin. Immunization had been shown to protect against tetanus and diphtheria - this was called prophylaxis (pro = for; phylaxis = protection). During the French experiments, the animals not only remained unprotected but developed severe reactions and died - thus the term anaphylaxis (ana = against; phylaxis = protection).

FOR SELF-TREATMENT OF ANALPHYLAXIS

When anaphylaxis strikes, you need help fast. Specifically, you need a does of epinephrine.

Now you can get the required epinephrine by means of self-injection. Here are three effective options:

a) EpiPen - A pressure-activated device that automatically injects epinephrine. Simply press it aginst your thigh; it automatically injects the proper amount with minimal pain.

b) Ana-Kit stinging insect kit - This small kit comes with a syringe containing epinephrine, notched to ensure the correct dose. You can inject a second or even a third dose as needed. The kit includes an antihistamine drug and a tourniquet.

c) Tubex - Another syringe containing epinephrine. The vial on the syringe is marked to indicate proper dosage.

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MAYO CLINIC HEALTH LETTER
July, 1986

COMMON SENSE CAN HELP PROTECT YOU FROM TAINTED DRUGS

"This is an act of terrorism, pure and simple," said James Burke, chairman of Johnson & Johnson, earlier this year, following news that a young woman in New York had died from taking Tylenal capsules that were laced with cyanide.

The death enchoed a similar tragedy in 1982, when poisoned capsules killed seven people in the Chicago area. The motives, methods and culprits behind these incidents remain a mystery. And through this spring, fears have surfaced of "copycat" tampering with such varied products as baby food and bubble gum.

IS THERE AN ANSWER?

Johnson & Johnson will spend nearly $150 million to halt production of its over-the-counter drugs in capsule form. It will replace them with a capsule-shaped tablet ("caplet") that industry experts say is more tamper-resistant. Other companies have developed a band of gelatin, resembling a piece of tape, that binds the top and bottom of a capsule. One manufacturer uses sound waves for a type of spot weld on its capsules. Food and beverage manufacturers are using seals for their packages. But no method is 100 percent foolproof.

WHAT CAN YOU DO?

How can you avoid taking drugs that have been tampered with? Your best safeguard is a careful inspection of the medicine before you take it. When you shop for drugs, we endorse the following guidelines from the United States Pharmacopeial Convention, which sets drug standards for America.

PACKAGES

a) Is the outer wrapping intact?
b) Are there bits of paper or blue on the rim of the bottle, indicating it once had a seal?
c) Is the package overfilled or underfilled?
d) If the container is unsealed, is the cap secure?
e) Do the box and its outer container have the same information and lot number?

LIQUIDS

a) Does it have the usual color and consistency?
b) Are there particles at the bottom or suspended in the solution?
c) Is there an unusual odor or taste?

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TABLETS

- a) Are they the same color and texture as usual?
- b) Are they spotted or scratched?
- c) Do they all have the same imprint?
- d) Are they all the same size?

CAPSULES

- a) Are they cracked or dented?
- b) Do they have their normal shiny appearance, or are some dull, with fingerprints on them?
- c) Do they all have the same imprint - in the same place?
- d) Are they of uniform size and color?
- e) Do all capsules appear to have about the same amount of contents?

TUBES AND JARS

- a) Is the bottom of the tube firmly sealed?
- b) Are ointments and creams smooth? Beware of any that appear gritty, or whose elements have separated.

Keep in mind that not every change in appearance is a signal of tampering. Also, the number of medications that are tampered with is extremely small (perhaps only a handful of the nearly one billion capsules Americans purchase annually).

If you are suspicious of medicines, play it safe and take the substance to a pharmacist, a physician or the police. It's wise to be aware of potential danger, but the risk of tampering is very slight. Common sense is your best protection.

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MAYO CLINIC HEALTH LETTER
July, 1987

SPIDER BITES
Black Widow and Brown Recluse can be lethal

When it comes to spider bites, we have good news, bad news and some words of caution.

First the good news: out of more than 30,000 species of spiders throughout the world, only about 50 are known to bite humans. Of these, most lack the biting power or venom to cause much harm.

The bad news is that two spiders, the black widow and brown recluse, can be deadly. Worse, they show up in residential and recreational areas. Children and the elderly are at greatest risk for severe reactions.

As to caution: the exact type of spider bite may be difficult for your physician to recognize. Effective treatments are available, but they require prompt, accurate diagnosis.

BLACK WIDOW

Of America's dangerous spiders, the most widely known is Latrodectus Mactans, or black widow. The nickname comes from an old legend that the female devours the male after they mate. Not so - but only the female, which is larger and heavier than the male, is a danger to humans.

The black widow is found throughout the world, especially in temperate and tropical regions. It spins a web in dry, dimly lit places.

Given these preferences and the fact that flies are a major source of its food, the black widow often lives near privies. Use of indoor plumbing limits your risk of being bitten at home, but take special care at campsites. Many black widow bites are on the buttocks and genitals, but any area of the skin may be affected.

Fortunately, the black widow (like most web-spining spiders) has limited vision. But it is aggressive and will attack on slight provocation. In the United States, most bites occur between April and October.

The black widow's bite resembles a pinprick. Some victims are not even aware of the bite. At first, there may be only slight swelling and faint red marks. Within a few hours, though, intense pain and stiffness begin. Other symptoms may include chills, fever, sweating, nausea and severe abdominal pain.

If you think you've been bitten by a black widow, seek medical aid immediately. First aid is of limited help. Persons younger than 16 or older than 60, especially those with a heart condition, may require a hospital stay.

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The vast majority of victims respond well to specific therapy with antivenom, but black widow bites have caused death from heart and lung failure.

In typical cases, pain will lesson after a few hours but may return over the next two or three days. A week may pass before you feel well again.

BROWN RECLUSE

Loxosceles Reclusa, a brown recluse, is another type of spider that is gaining in notoriety. As its nickname suggests, the brown recluse is not agressive. When is does bite, however, the effects can be extremely painful and disfiguring. In rare cases, death can result.

The brown recluse is common in South America and the southern United States. It prefers dark, dry places - which include cargo being shipped by freight or rail, enabling the brown recluse to be transported to any part of the country.

In residential areas, it spins an irregular web in gardens, barns and sheds. Closets and attics are favorite locations: be sure to inspect or clean all clothes that you take out of storage.

Outdoors, the brown recluse prefers open fields and rocky bluffs.

Like the black widow, the brown recluse has a bite that few people notice at first. Within two to eight hours, severe pain begins at the site of the bite. Other possible symptoms include fever, weaknesses, vomiting, joint pain and a diffuse rash.

The spider's venom contains an enzyme that destroys cell membranes in the wound area.

Clots block blood vessels, leading to gangrene. Within 24 hours the bite site can erupt into a "volcano lesion": a hole in the flesh that forms because of damaged tissue. This open wound may range from the size of an adult's thumbnail to the span of an man's hand.

The most appropriate treatment is controversial. An effective antivenom is not generally available. One approach: high doses of cortisone-type hormones, combined with surgical removal of the damaged tissue. A recent report suggests that treatment with dapsone (a drug used mainly for leprosy) may reduce the degree of tissue damage. Skin grafting may eventually be necessary for large wounds. Full recovery may take several months; scarring may remain.

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KEEP CALM

Every summer brings reports of people who are bitten by spiders. Many people fear spiders, but it's important not to overreact. In fact, many "spider bits" actually result from other insects. Remember, most spiders are harmless, and they play an important role in the balance of nature.

You might not want one for a pet, but common sense will let you continue to share and enjoy the outdoors with these creatures.

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MAYO CLINIC HEALTH LETTER
September, 1986

NOTHIN' SAYS LOVIN' LIKE A SAFE MICROWAVE OVEN

You might suppose the greatest danger from microwave ovens would be radiation leakage. Not true, the most common problems are more mundane. But they deserve careful attention. We recommend these guidelines, taken, in part, from the American Council on Science and Health, an independent, nonprofit consumer association.

a) Electrical shock is the most frequent danger. Be sure your microwave is installed properly, with a circuit that is rated for at least 15 amperes of current and an outlet that is polarized and grounded. Check the electrical cord and plug regularly for signs of damage.

b) Fire can result if you overheat food that is on paper or plastic. Be sure the exhaust outlets are free of blockage (they are located in different places on various models).

c) Leaks usually are not a problem if the door, hinges and seal are intact. If you suspect any damage, have a qualified service person check your oven. Several devices are for sale to consumers for checking microwaves, but these generally are unreliable, says the Food and Drug Administration.

d) Explosions - Make sure any dish you put in your microwave is safe for microwave use. Glass containers not designated for microwave use may explode upon removal.

e) Burns can take you by surprise. Microwaves heat the food while keeping dishes cool. Always use a hot pad to take containers out of a microwave, and be careful about the first bite: it can be very hot. Also, microwaves do not heat the food evenly. Be careful to stir and mix food thoroughly before eating. The danger of "hot spots" makes it unwise to use microwaves for infant formulas and baby food.

Guard against vapor burns. Many recipes require the use of waxed paper, Saran Wrap or similar products to cover microwave dishes. This is done to retain moisture and to ensure the proper cooking temperature.

If the covering has a bulge upon completion of cooking, beware. Hot vapors have built up inside the dish. Remove the wrap with extreme caution or you may suffer a serious vapor burn.

Our suggestion: before removing the dish from the microwave, open the door and allow the dish to stand for a minute or two, or use a lengthy kitchen utensil to make a small puncture in the covering. Either of these methods will minimize the hazards of a vapor burn.

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July-August 1987
Volume 39, Number 4

THE NATIONAL CANCER INSTITUTE CANCER CONTROL OBJECTIVES FOR THE NATION: 1985-2000
A SUMMARY

Guy R. Newell, MD

Four groups of experts convened by the National Cancer Institute quantitated the potential for reducing the cancer death rate substantially by the year 2000. The achievement of this goal depends on the application of existing knowledge among many segments of society. While some question the ability to achieve the goal by 2000, the real challenge is to translate the existing knowledge into action as quickly as possible, said Guy R. Newell, M.D.

In 1986, the National Cancer Institute (NCI), based on the deliberations of 4 working groups (Table 1), issued a set of guidelines for reducing the cancer death rate by 25% to 50% of the 1980 level by the year 2000 (Table 2). This goal was determined to be feasible through full and rapid application of existing knowledge of cancer prevention, screening and detection, and state-of-the-art treatment methods. These objectives were also meant to be used for regional cancer control efforts nationwide and to assist in the coordination of health promotion-related activities.

The attainment of these objectives depends on targeting prevention actions to smoking and diet, screening actions to breast and cervix, and application of the best available treatment to all segments of the population. A summary of the specific actions is given in Table 3, and their rationale is discussed briefly below.

SMOKING

Among smokers who stop, cancer risk returns to near normal within 15 years after smoking cessation. This benefit holds for all smoking-related cancers and accrues even after many years of smoking. The first Surgeon General's report on smoking and health was issued in 1964. In 1965, 52% of men and 34% of women were smokers. In 1983, the figures were 35% men and 30% for women, a decrease of 33.2% among men and 13.7% among women.

A decrease in lung cancer deaths among white men (all ages combined) was recently demonstrated. This indicates that the reduction in cigarette smoking that began in 1964-1965 has resulted in a decrease in lung cancer deaths. The use of smokeless tobacco, however, has increased sharply among young men. An intensive effort is needed to increase the number of ex-smokers and to prevent initial use of all forms of tobacco.

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DIET

It has been estimated that 35% of cancer deaths may be related to dietary components, although the figure could range from 10% to 70%. By using the mid-range estimate of 35% dietary changes could translate into the savings of about 150,000 lives a year. A more conservative estimate of the effect of appropriate diet still would represent a potentially significant impact on the reduction of cancer deaths. It also should be noted that the direct association between dietary intake and cancer has not been established.

At a minimum, the NCI estimates that 30,000 lives could be saved in the year 2000 if Americans were to modify their dietary habits. If early clinical trials of chemopreventive agents continue to show positive results, it is possible that chemoprevention, together with alterations in diet and nutrition, could save more than the minimum estimate of 30,000 lives.

SCREENING

It is generally accepted that cancer deaths can be prevented by screening for cancers of the cervix and breast. Cervical cancer screening has long been accepted as effective. Proper application of the Pap test should reduce deaths from invasive cancer of the cervix to virtually zero.

The Survey indicates that, at most, 79% of women 20 to 39 years old and 57% of women 40 to 70 years old follow recommended guidelines for screening for cervical cancer. At a minimum every women who is sexually active should have two consecutively negative Pap tests one year apart. Following these two consecutively negative tests, every woman should have a Pap test every one to three years, depending on the recommendations of her physician.

Several studies now show that the use of mammography reduces deaths from breast cancer; however, surveys indicate that only 15% is an overestimate because many of these mammograms were performed for diagnostic purposes rather than for screening asymptomatic women. Deterrents to the use of mammograms include concern about radiation exposure, unnecessary biopsies and overdiagnosis, and financial costs without coexistent reimbursement mechanisms. Acceptance of mammography depends greatly on whether the physician recommends it. Aggressive education of primary care physicians on the benefits of mammography in asymptomatic women will be required.

TREATMENT

The likelihood of a person with cancer surviving at least five years is now 49% of those diagnosed from 1976 through 1981, compared with 38% for those diagnosed from 1960 through 1963. If lung cancer is removed from the 1976-1981 figures, 5-year survival is 56%, and for most cancer sites this represents a cure. Dramatic improvement has occurred in survival and cure for some cancers, such as Hodgkin's Disease (74%) and testicular cancer (87%).

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A recent National Institutes of Health Cancer Consensus Development Panel concluded that breast cancer mortality could be reduced through adjuvant (postsurgical) therapies. These included chemotherapy in premenopausal women with positive lymph node involvement, and hormonal (tamoxifen) therapy in postmenopausal women with positive lymph nodes and positive estrogen receptors.

The NCI believes that accelerated dissemination and application of existing state-of-the-art cancer therapy would increase significantly national survival rates. The improved survival would translate into a reduction in the cancer mortality rate of 10% to 15%.

SUMMARY

Providing information on prevention, screening, and treatment to the public and to health care professionals is essential in any effort to curb the cancer death rate. In that regard, several mechanisms are in place for bringing the benefits of clinical research to individuals (Table 4). Ultimately however, achieving the goal of reducing the cancer death rate by 25% to 50% by the year 2000 depends on (1) the reduction in tobacco smoking by 50% from 1980 levels, (2) the adoption of a prudent low-fat, high-fiber diet by all Americans, (3) greater utilization of screening for cancers of the cervix and breast, and (4) widespread application of gains in state-of-the-art cancer treatment methods.

TABLE 1. CHAIRPERSONS OF THE 4 WORKING GROUPS

Dr. Lester Breslow
Chairman, Working Groups
Division of Cancer Control
Jonsson Comprehensive Cancer Center
Los Angeles

Prevention Working Group	Dr. Philip Cole School of Public Health University of Alabama
Screening and Detection Working Group	Dr. David Eddy Research Duke University Durham, NC
Treatment Working Group	Dr. Paul Engstrom Department of Medical Oncology Fox Chase Cancer Center Philadelphia
Surveillance Working Group	Mrs. Dorothy Rice Department of Social and Behavioral Science University of California San Francisco

TABLE 2. ESTIMATED REDUCTION IN CANCER MORTALITY BY THE YEAR 2000

OBJECTIVE	METHOD	ESTIMATED REDUCTION
Prevention	Diet Fat reduction to 25% of total calories Fiber increase to 20 to 30 g/day	8
	Smoking Reduction in adult smoking prevalence to 16%	
	If achieved in year 2000	8
	If achieved in year 1990	15
Screening	Achievement of objectives in Table 3	15
Treatment	Application of current state-of-the-art treatment for specific cancer sites	
	With no future changes in state-of-the-art therapy	10
	With current trend in state-of-the-art survival maintained (0.5%/yr all sites)	14
	With accelerated gains in state-of-the-art treatment (1.5%/yr, all sites)	26
TOTAL RANGE OF MORTALITY REDUCTION		25 to 50+

TABLE 3. SUMMARY OF ACTIONS TO ACHIEVE CANCER CONTROL OBJECTIVES

ACTION	TARGET	YEAR 2000 OBJECTIVES
Prevention	Smoking	Reduce the percentage of adults who smoke from 34% (in 1983) to 15% or less.
	Diet	Reduce average consumption of fat from 37%-38% to 30% or less of total calories.
		Increase average daily consumption of fiber from 8 to 12 g to 20 to 30 g.
Screening	Breast	Increase the percentage of women ages 50 to 70 who have an annual physical examination coupled with mammography to 80% from 45% for physical examination alone and 15% for mammography.
	Cervix	Increase the percentage of women who have a Pap smear every 3 years to 90% from 79% (ages 20 to 39) and to 80% from 57% (ages 40 to 70).
Treatment	Transfer Research Results to Practice	Increase adoption of state-of-the-art treatment.

TABLE 4. NETWORK OF CANCER CONTROL RESOURCES

Community Clinical Oncology Program
A major research initiative intended to involve community physicians in clinical trials according to National Cancer Institute - approved research protocols, thereby increasing use and transfer of state-of-the-art therapy.

Cooperative Centers Program
A program to upgrade the skills of community physicians and other health professionals in treating cancer patients through the use of well-defined protocols at affiliated hospitals, quality control of patient management, and continuing education activities.

Cancer Centers Program
A program to coordinate grants for the support of projects in cancer research, education, and control at educational and research institutions in the United States. The purpose is to extend knowledge and understanding of the causes, mechanisms, prevention, detection, diagnosis, and treatment of the miltiple forms of cancer through the development of either specialized or broad multidisciplinary programs in basic and clinical cancer research.

Clinical Cooperative Groups
A program of several multi-institutional consortia of clinical investigators to conduct trials of cancer treatment.

Physician Data Query
A computerized information system about cancer treatment and research protocols designed for physicians and accessible via personal computers through the National Library of Medicine and through vendors of commercial information.

Surveillance, Epidemiology, and End Results Program
The major component of NCI's system for tracking cancer incidence, patient survival, and mortality, consisting of 11 population - based cancer registries serving 12% of the nation's population.

Cancer Information System
A national, toll-free telephone service providing immediate access to answer to cancer-related questions from cancer patients, their families, the general public, and health professionals.

The Journal of the American Medical Association
December 25, 1987

A PIECE OF MY MIND

MY FRIEND

Brett is intensely curious about the rapidly enlarging world about him. His probing curiosity about life stimulates the adults around him to inquire more actively about their own lives. He is like most other 3-year-olds, I think: full of delightful mischief, granting smiles without hesitation and rapidly retreating to tears at those times when life is just too much bigger than he is. And, like many children, he cannot conceal a certain charming, if smug, satisfaction as he masters each new developmental task. Those task often come hard for Brett.

Brett has many other friends. Some, such as I, are new friends. Others, such as Grandma, Grandpa, and Daddy, go way back to before the accident that he now pretends not to remember. The accident? Brett's mother and baby brother, Matthew, were killed by a drunk driver in a violent accident on a softly beautiful starlit evening last summer. I did not know the driver, but I know he had spent the day enjoying a party with friends and relatives. It was a day of happiness and sharing, of warmth and comradery. It was also a day of drinking.

I grew up in a home in which the consumption of alcohol was uncommon, but not condemned. Nevertheless, the importance of responsibility and the possible adverse consequences of drinking and driving were emphasized. I can still easily recite a litany of facts about alcohol consumption and driving: a quarter of a million Americans have died in alcohol-related accidents in the last decade; one American life is lost every 20 minutes in an alcohol-related accident; half of all Americans will be involved in an alcohol-related accident during their lifetimes; alcohol-related crashes are the leading cause of death among Americans between the ages of 16 and 24 years; 2000 persons are injured each day in alcohol-related accidents; 2 million drunk-driving collisions occur each year; 80% of Americans drive after drinking; drunk drivers cost US taxpayers in excess of $20 billion annually; only about one in 1000 drunk drivers on the road is arrested. I knew all this, but I really did not know anything about the human cost of drunk driving until I met my new friend Brett.

At least one person told the drunk driver he ought not drive, but the warning was waved off. No one stopped him and no one tried to save his life by preventing him from driving while he was so obviously drunk. He also died in the fiery crash, burned alive in the first few minutes after he wove repeatedly across the center line and crashed at 60 mph into the car carrying Brett. Some might say that Brett is lucky: he suffered no brain damage. Intellectually he is quite alive - I believe he will go to college one day. But Brett is paralyzed below the level of his second cervical vertebra. His arms and legs will never move. He cannot breathe at all on his own, nor will he ever.

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A specialist in pediatric intensive care medicine, I see and care for many very severely ill and injured children. The jarring horror of my first moments with Brett ripped a still unrepaired hole in the wall of objectivity that usually protects me from the pain of seeing a seriously injured child.

"He's not breathing," shouted the flight nurse over the scream of the engine as we unloaded the child from the helicopter and rushed into the emergency department. The neurosurgeon and I examined the form below us. The cherub was motionless, save for a grimace when we ventilated him by mask. "Can you open your eyes?" urged my colleague. When he did promptly open his eyes we both gasped, staring almost uncomprehendingly at one another then back to the figure on the table. The frightened young eyes reached out so powerfully in their panic that we felt ourselves pulled to the child. The reality of the nearly unimaginable injury was upon us.

"Oh, God, it's his C-spine—this kid's a quad." The words were whispered. They would have been wholly unbearable if spoken any louder. Even gently whispered, those words conveyed a sentence of harsh finality known to all in the room, save one. A few slow, deep breaths and physicians and nurses resume control and functions: "We're sorry, Brett. You've been in a car accident. This is the hospital. We're doctors and nurses. We're going to help you, honey. Don't you have the most handsome blonde hair we've seen today? This is Tickless, our stuffed bear. Can he snuggle close by you? He loves little boys." Later, Brett and his father would cry together, as one generation struggled to be brave for the next, unable to soften the story that had to be shared.

A portable ventilator now breathes for Brett. The annual cost of providing his necessary medical and nursing care exceeds $180,000. The man who caused the accident was uninsured. The cost in anguish and emotional pain for Brett's family and for the family of the drunk driver cannot be guessed. The lives of all involved will never be the same.

Although the police report assigned the responsibility for the accident to only one man, we are all to blame. Why do we share this burden? Because we have driven after drinking. Because we have welcomed friends into our homes, entertained them with alcohol, then waved them warmly into the night. Because we have laughed at and accepted public intoxication. Because we have tolerated weak and inconsistent enforcement of drunk driving laws. Because we have accepted lenient sentences for drunk drivers. Because we have conveniently ignored signs of alcoholism in our patients.

Perhaps we can only truly know that which we have experienced. My friendship with Brett has added much to my understanding of the realities of drunk driving and of life. Few intend to hurt or kill others, yet it happens, and the consequences fill our forevers.

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I grieve with Brett for the mommy who can no longer kiss and hug away the hurts of childhood, and for the little brother who will not play with him. I share with him the emptiness of a football lying unthrown by the fireplace, of the unopened bag of marbles on the table beside his bed, of the laughing horse-play and the flirtations of young manhood that may never come.

Yet, life goes on. I will not demean the resilience of man or child by ascribing to Brett extraordinary bravery or superhuman determination. He is, after all, a little boy. He still laughs and he still cries. He manipulates people and he likes french fries and lots of ketchup. He uses a computer masterfully with a mouth control that also enables him to drive his own wheelchair. Such is our nature, about which Brett has taught me so much: given the slightest toehold, we dig in and we grow and survive, but the shocking ease with which beautiful things can be broken haunts us. Twenty-five thousand Americans die each year in auto accidents involving alcohol. Two of them are missed a great deal by my little friend Brett.

- Thomas J. Poulton, MD
Omaha

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READER'S DIGEST

THINK HEALTHY

PSYCHOSOMATIC ILLNESS: MORE THAN WE IMAGINE

Recent scientific research shows that our emotions profoundly affect our health and that these emotions are within our control

By Catherine Houck

For much of my life, I was bothered by periodic and unexplained eyestrain. Most exasperating, it seemed to strike at times when I most needed the cooperation of my eyes during exam week in college, for instance.

When one ophthalmologist said my eyestrain might be psychosomatic, I was outraged. Mistaking the term for hypochondria, a neurosis, I thought he meant I was imagining my troubles, or somehow purposely bringing them on myself.

Then, through a biofeedback technique that measured the amount of tension in my facial muscles, I discovered that whenever I felt anxious I clenched my jaw, and if I clenched my jaw long enough, the muscles around my eyes tensed up, probably reducing the blood circulation. When I learned to relax my facial muscles, my eyestrain vanished.

I did have a psychosomatic ailment: a real physical condition brought on the body's reaction to stress.

Says Dr. William L. Webb, secretary of the Academcy of Psychosomatic Medicine, "The idea that states of mind, relationships, personalities or lifestyle affect the body is not new, but it only recently has gained the attention of doctors trained in science and technology."

To understand how stress can affect health, consider your body's alarm reaction, the way it suddenly prepares you for fight or flight in an emergency: adrenalin floods into the bloodstream, causing the heart to pound. The body suspends nonessential tasks, such as digestion, to divert blood to the muscles and the brain. Breathing becomes shallow; muscles tense, particularly in the lower back, neck and shoulders; the spleen releases red blood cells into the bloodstream to increase the oxygen supply; and the liver sends out stored vitamins and nutrients in the form of sucrose.

Surprisingly, these elaborate preparations for action appear with little provocations: a college exam, a lovers' quarrel, criticism from the boss. When life is regularly filled with such stresses, the continual overmobilization of the body is debilitating.

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Some organs of the body and some diseases seem to be more subject to emotional influences than others, though evidence is building that suggests emotions play an important part in virtually all illnesses.

A connection between emotions and heart disease is being investigated by James J. Lynch, professor of psychology and co-director of the Psychophysiological Clinics at the University of Maryland School of Medicine. Lynch has documented in his book, The Broken Heart, that happy relationships with spouses, friends and relatives not only can be good for mental health but also may protect against cardiovascular disease.

On the other hand, using computer technology, Lynch's research team has recently discovered that blood pressure rises significantly the moment you speak. The higher your blood pressure while at rest, the more it tends to go up while speaking. And if you are talking to strangers, arguing or being criticized, laboratory observations indicate the possibility of blood-pressure elevation as high as 40 to 50 percent above resting levels. This led Lynch and his colleagues to the surprising conclusion that hypertension is importantly linked with problems of communication.

Studies based on 4900 Swedish and American men have shown "high psychological strain" from job pressures to be a factor in cardiovascular illness. It's not the bosses but the bossed who get sick. Heart disease is more prevalent in workers whose jobs combine heavy demands with little ability to influence how their tasks are done.

Another field that has always interested psychosomatic researchers is that of the digestive disorders, since the gastrointestinal system often reacts more directly to emotional ups and downs than any other part of the body. A disease such as osteoporosis, for instance, in which bones become thin and brittle, seemed to be caused by a long-term lack of calcium. Now it's believed that even if supplements are taken, the calcium won't be absorbed if emotional problems cause continual upheavals of the sensitive digestive system. Researchers also have found that sustained stress causes more hydrochloric acid than usual to pour into the stomach.

Ailments such as the common cold were once thought to be transmitted directly by exposure to germs, but we've since learned that we catch a cold when our immune system is weakened. More and more studies are showing that stress has a potent weakening effect on the immune system.

Increasingly accepted is the theory that stress, badly handled, plays a part in who gets cancer. In a study of idential twins in which one suffered from terminal cancer while the other did not, Dr. William Greene, professor of medicine and psychiatry at the University of Rochester Medical Center, found that in each pair, the one who got cancer recently had been through an emotional upheaval, while the other's life had been tranquil.

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In summary, the body and mind are as intermixed as the yolk and white in a scrambled egg. But, fortunately, there are ways we all can stay well during stress. Here are some of the most important:

a) Experience your feelings. "Why do some people come through a crisis such as bereavement in good health, while others get sick?" asks Dr. Peter H. Knapp, professor of psychiatry and chief of psychosomatic services at Boston University School of Medicine. His reply: "I believe that the ones who stay healthy actively grieve. They think about what's happened to them and gradually work it through. If you lock feelings away, it seems as if your body mourns for you by getting sick."

b) Talk out bad feelings. If you're furious at your sister for not helping to care for your ailing mother, try to deal with the situation openly, instead of retreating into a grim silence or angrily attacking her. Show your willingness to solve the problem. Preventing needless discord at home is important. In one study of cardiac patients seen in a hospital emergency room, 76 percent had suffered heart attacks following a recent major family crisis.

c) Avoid making too many changes at once. Stress can be induced by any change that necessitates adjustment to a new or difficult situation-life after the recent death of a spouse, coping with a new baby, developing financial woes, or even a happy event such as winning a lottery. Change is stressful only when too much hits at once, and every individual has a responsibility to himself to know when he's overloaded.

d) Learn how to take it easy. In a state of true relaxation, the heart rate slows, breathing becomes deeper and more even, muscles loosen, hands and feet feel warm, the mind feels calm and at peace, and the entire body feels refreshed. Effective ways of relaxing are deep-breathing, stretching, meditation and biofeedback (which requires a few sessions of professional training).

e) Turn to your friends. Inadequate social ties have been compared to nutritional deficiencies; some psychiatrists believe that just as a well-nourished person is less likely to get sick someone with a well-nourished social life is more resistant to illness.

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f) Exercise adequately. Even moderate exercise has been shown to produce high levels of endorphins, the body's own morphinelike substances. By exercising consistently, we seem to tune up the endorphin production mechanism. Dr. Lee S. Berk of Loma Linda University Medical Center in California measured endorphin levels in both athletes and sedentary people and found that those who exercised regularly produced greater amounts of endorphins during stressful situations and also produced them more rapidly, indicating they can handle everyday hassles better than inactive types can.

g) Decide to live. When Dr. Viktor Frankl studied survivors of Nazi concentration camps to learn why they had lived having strong reasons for wishing to live was evident. Perhaps what is most important in avoiding stress-related disease is to have enough reason for wanting to stay healthy.

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MAYO CLINIC HEALTH LETTER
July, 1987

THE PLACEBO
An ancient and still powerful remedy

If you're ill, what helps you feel better? Early Egyptian doctors prescribed crocodile dung and swine's teeth. Physicians in ancient Greece recommended a variety of animal bloods. In 17th-century London, approved medicines included oil of frog sperm, human sweat, worms and dried viper. Patients often felt better after such therapies.

Today some people insist they find relief through folk medicines such as chelation therapy, laetrile, copper bracelets and megavitamins.

For centuries, healers of all kinds have helped the sick. Throughout most of this time, the medications used had no proven effectiveness of the specific disorders for which they were prescribed. Surprisingly, though, such remedies were not always useless. Now we know that all remedies - from lizard's blood to laetrile - actually help relieve symptoms in some cases.

What explains the healing power of such treatment? It's a phenomenon called "the placebo effect." Poorly understood by the public and, until recently, by doctors, the placebo effect is now coming under increasing scientific scrutiny. The placebo effect brings benefit to some patients when no active medicine is involved. What's more, the placebo effect can enhance the value of "real" drugs or other treatments.

WHAT IS A PLACEBO?

A placebo drug contains no active ingredients. The sugar pill and salt water injection are well known examples.

The first studies of the placebo effect were conducted in the 1950s. The effects of new active drugs in treating certain disorders were compared with the effects of placebos. Scientists were surprised to learn that the effects of active drugs and placebos sometimes are similar. Since that time, many studies have confirmed the potency and sometimes remarkable effects of placebo therapy.

The word "placebo" is derived from Latin, meaning "to please" or "to serve." Although much of modern drug therapy is based on medicines with proven effects, we now know that the placebo effect is a factor in all treatment, with or without drugs.

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THE EFFECTS ARE REAL

In those earlier years, the public and many physicians remained unconvinced of the potential value of placebo therapy. Some regarded placebo therapy as medical quackery. Worthless treatments often were characterized as "no more useful than a placebo."

Today we know that placebos can mimic the effect of almost any active drug or therapy. In one out of three patients, pain after abdominal surgery can be significantly relieved by placebo therapy. Sometimes the relief equals that obtained from a standard dose of morphine.

Cough, headache, insomnia, nausea and many other symptoms, including symptoms of allergy and arthritis, sometimes are relieved by placebo therapy. Blood pressure and blood sugar can be altered by it. So can the stomach's production of acid.

PLACEBO CAN BE TOXIC OR HABIT-FORMING

Placebos even can be toxic. About 10 percent of the time, people receiving placebo therapy experience side effects - symptoms including diarrhia, fatigue, skin rashes, visual blurring and rapid heartbeat.

Sometimes tolerance to the placebo develops, and increasing amounts may be required to sustain the initial relief.

Placebos also can be habit-forming. Occasionally a placebo medicine must be reduced gradually to prevent what physicians call a "withdrawal reaction."

Placebos probably can even kill. Voodoo death may be an extreme example of the potency of the placebo effect.

HOW DO THEY WORK

If placebos can relieve symptoms, how do they work? Although physicians no longer doubt that the effects of placebos are real, the reasons for the placebo effect remain unclear. Some theories include:

a) Biochemical - Chemicals called endorphins occur naturally in the brain. When activated, they kill pain in much the same manner as narcotics. Placebos may relieve pain by activating these natually occurring pain killers.

Other brain chemicals, known as neurotransmitters, also may play a role in the placebo effect. Researchers believe these potent chemicals, which affect how you think, feel and behave, may relieve symptoms of many disorders.

Scientists now know that placebo therapy can influence the production of hormones within the body. Well-documented examples include release of cortisone like hormones, epinephrine and other hormones produced by the adrenal glands.

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b) Psychological - The "power of suggestion" often is involved in placebo therapy. Because the patient believes the treatment will work, it does.

For this reason, physicians themselves are placebos. A skilled physician provides reasurring explanations that ease anxiety. Experienced doctors demonstrate concern and enhance their patient's sense of control over illness.

The medical degree prominently displayed, the white coat, the aura of authority, the gentle touch and the very act of writing a prescription - all have healing powers. Thus, the placebo effect is present in much of medical practice even when placebos in the form of drugs or devices are not used.

OTHER FACTORS

When considering potential effects of placebos, physicians evaluate many possibilities. Here are factors that can affect the action of a drug:

a) How you take it - Placebos can be swallowed, inhaled, inserted, injected or applied to a body surface. For many people, an injection promises more potent relief than an oral medication.

b) Taste and Smell - For some people, a drug with an unpleasant taste or smell may be more effective than an identical medication that is tasteless and odorless.

c) Packaging - The size and color of a pill or liquid drug, and even the box it is packaged in, may affect its therapeutic benefit.

d) Vintage - New medicines often work better than older drugs because doctor and patient alike place great faith in modern technology.

e) Cost - Does inexpensive mean ineffective? People sometimes think so. When they do, the drug indeed may be less helpful.

IN SUMMARY

Placebo therapy has a legitimate role in modern medicine. While medical therapy has advanced rapidly over the past 50 years, many ailments still lack a specific form of treatment. In such cases, the placebo effect sometimes can provide significant relief with little risk of side effects. And even when a treatment of proven effectiveness is used, immediate relief sometimes is due to the placebo effect.

With continued research, we will understand the action of placebos more fully. In the meantime, remember these astute observations:

a) A merry heart doeth good like a medicine - Holy Bible.
b) There is nothing good or bad, but thinking makes it so
 - William Shakespeare.
c) For an injured child, a mother's tender kiss sometimes can give more
 relief than anything modern medicine has to offer.

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MAYO CLINIC HEALTH LETTER
September, 1986

CAN YOU BECOME ALLERGIC TO THE 20TH CENTURY?

We live in an age of chemicals. Food additives ... air pollution ... agricultural compounds - the list seems endless. Are these agents harmful to your health? Some can be; others are not.

Most of us enjoy good health in spite of exposure to chemicals whose very names sound intimidating. We depend upon the government to monitor use of chemicals and to ensure a safe, reasonably healthy environment. We take precautions to avoid unnecessary exposure to chemicals.

Some people are not so fortunate. They are ill, and they believe the entire 20th century is to blame. These individuals often insist that they are allergic to virtually everything in our modern environment. Their symptoms are genuine, but allergy is not the cause. Most often their problem is emotional turmoil.

In North America, this condition is called "20th century syndrome." In Europe and Australia, doctors may refer to it as "total allergy syndrome." Regardless of its name, this condition always is difficult to treat.

A FRINGE GROUP IN MEDICINE

Patients receive the false diagnosis of allergy from a group of physicians at the fringe of orthodox medicine. These "clinical ecologists" use a variety of tests. Some of the tests are valid and others are not.

In fact, there are few proven data about his problem. "Total allergy syndrome" has not been defined precisely, and doctors even disagree about the number of people who are affected by it. But despite this ambiguity, clinical ecologists prescribe treatments that are costly and disruptive to a patient's life. The treatment also can result in marked disability.

Advised to avoid "unnatural elements," patients may quit work and move to the mountains or desert, living in a rustic home that has no synthetic materials. They carefully restrict their diet, shunning all but organic foods (fish and a peach one day, raspberries the next and broccoli the following day). They drink several quarts of water to flush chemicals from their system and bathe with coconut oil rather than soap. But nothing seems to relieve the symptoms permanently.

WHAT ARE THE SYMPTOMS?

Scientific data are scarce, but these generalizations seem clear. The syndrome affects women more than men. Problems begin gradually. Patients report dizziness, impaired concentration, headaches and pain in the joints.

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Symptoms often intensify after an emotionally traumatic event such as the loss of a job or death of a child. Patients usually reject a doctor's opinion that these symptoms have no physical origin. They might visit upwards of 100 physicians and other health practitioners before someone diagnoses their problems as allergy. Preoccupation with illness becomes a way of life. Gradually, some patients come to believe that almost everything in the environment may be aggravating their problems.

HOW DANGEROUS IS OUR ENVIRONMENT

Chemicals and pollutants, of course, can cause illness. Foods can cause bona fide allergic reactions. People with asthma can react adversely to irritants such as ozone, exhaust fumes, cigarette smoke, strong flower odors and even a change in temperature. These problems have a specific cause and effect. But there is no evidence that a person can become truly allergic to the entire lifestyle and environment of our times.

WHAT TREATMENT IS AVAILABLE

We must emphasize that allergies are not the source of this problem. A careful evaluation can reveal any physical illness. Most of these patients would benefit from treatment for emotional stress.

Effective treatment methods are available. But most patients refuse to help. They cling to a problem of "allergy therapy" that is unscientific, expensive and potentially harmful. Ironically, by shunning the 20th century, these patients deny themselves the benefits of modern psychiatry that could help them the most.

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CHECK OFF EACH READING ASSIGNMENT AS COMPLETED

	Date	2 Newspaper Articles (Record Page Numbers)	1 Journal Article (Record Page Numbers)
WEEK ONE			
WEEK TWO			
WEEK THREE			
WEEK FOUR			
WEEK FIVE			
WEEK SIX			
WEEK SEVEN			
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WEEK NINE			
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WEEK FIFTEEN			
WEEK SIXTEEN			

*Place a star by the page numbers of the articles you enjoyed reading the most.

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